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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: 4HCK

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245270**
2.STATE VENDOR OR MEDICAID NO.
(L2) **823957600**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **09/01/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **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):

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 09/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/22/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 245270

September 22, 2015

Ms. Margaret Holm, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

Dear Ms. Holm:

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 August 31, 2015 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered
September 22, 2015

Ms. Margaret Holm, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, MNinnesota 55972

RE: Project Number S5270024

Dear Ms. Holm:

On August 5, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 10, 2015. (42 CFR 488.422))

This was based on the deficiencies cited by this Department for an extended survey completed on July 17, 2015. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On September 1, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 31, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 17, 2015, as of August 31, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 31, 2015.

However, as we notified you in our letter of August 5, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 17, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter.

• Per instance civil money penalty of  for the deficiency cited at F323, (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245270 | A. Building<br>B. Wing | 9/1/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOLDEN LIVINGCENTER - WHITEWATER | 525 BLUFF AVENUE<br>ST CHARLES, MN 55972 |

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 **F0176**<br>Reg. # **483.10(n)**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **F0225**<br>Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **F0280**<br>Reg. # **483.20(d)(3), 483.10(k)(2)**<br>LSC | Correction Completed **08/26/2015** |
| ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **F0323**<br>Reg. # **483.25(h)**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **08/26/2015** |
| ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | Correction Completed **08/26/2015** |
| ID Prefix **F0497**<br>Reg. # **483.75(e)(8)**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **F0520**<br>Reg. # **483.75(o)(1)**<br>LSC | Correction Completed **08/26/2015** | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | GPN/kfd | 09/22/2015 | 31217 | 09/01/2015 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

**Followup to Survey Completed on:** 7/17/2015

**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**

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245270 | A. Building<br>B. Wing **01 - MAIN BUILDING 01** | 9/19/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOLDEN LIVINGCENTER - WHITEWATER | 525 BLUFF AVENUE<br>ST CHARLES, MN 55972 |

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 | Correction Completed **08/31/2015** | ID Prefix | Correction Completed **08/29/2015** | ID Prefix | Correction Completed **08/31/2015** |
| Reg. # **NFPA 101**<br>LSC K0018 | | Reg. # **NFPA 101**<br>LSC K0029 | | Reg. # **NFPA 101**<br>LSC K0050 | |
| ID Prefix | Correction Completed **08/31/2015** | ID Prefix | Correction Completed **08/31/2015** | ID Prefix | Correction Completed |
| Reg. # **NFPA 101**<br>LSC K0076 | | Reg. # **NFPA 101**<br>LSC K0144 | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. #<br>LSC | | Reg. #<br>LSC | | Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | GS/kfd | | 25822 | 09/19/2015 |
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |
| | | | | |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 7/14/2015 | | | |

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered

September 22, 2015

Ms. Margaret Holm, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

Re: Reinspection Results - Project Number S5270024

Dear Ms. Holm:

On September 1, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 1, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

# State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 00942 | A. Building<br>B. Wing | 9/1/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| GOLDEN LIVINGCENTER - WHITEWATER | 525 BLUFF AVENUE<br>ST CHARLES, MN 55972 |

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

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **20255**<br>Reg. # **MN Rule 4658.0070**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **20570**<br>Reg. # **MN Rule 4658.0405 Subp.**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **20830**<br>Reg. # **MN Rule 4658.0520 Subp.**<br>LSC | Correction Completed **08/26/2015** |
| ID Prefix **21375**<br>Reg. # **MN Rule 4658.0800 Subp.**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **21426**<br>Reg. # **MN St. Statute 144A.04 Su**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **21530**<br>Reg. # **MN Rule 4658.1310 A.B.C**<br>LSC | Correction Completed **08/26/2015** |
| ID Prefix **21535**<br>Reg. # **MN Rule4658.1315 Subp.1**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **21565**<br>Reg. # **MN Rule 4658.1325 Subp.**<br>LSC | Correction Completed **08/26/2015** | ID Prefix **21665**<br>Reg. # **MN Rule 4658.1400**<br>LSC | Correction Completed **08/26/2015** |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | GPN/kfd | 09//22/2015 | 31217 | 09/01/2015 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|---|
| 7/17/2015 | | | | |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

ID: 4HCK

Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245270**
2.STATE VENDOR OR MEDICAID NO.
(L2) **823957600**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **07/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **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):

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 08/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically Submitted
August 5, 2015

Ms. Margaret Holm, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

RE: Project Number S5270024

Dear Ms. Holm:

On July 17, 2015, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

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

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

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

**Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not**

**immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;**

**Appeal Rights - the facility rights to appeal imposed remedies;**

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

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

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

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

**REMOVAL OF IMMEDIATE JEOPARDY**

We also verified, on July 16, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

**DEPARTMENT CONTACT**

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

**Gary Nederhoff, Unit Supervisor**
**Minnesota Department of Health**
**Health Regulation Division**
**18 Wood Lake Drive Southeast**
**Rochester, Minnesota 55904**
**Telephone: (507) 206-2731**
**Fax: (507) 206-2711**

**NO OPPORTUNITY TO CORRECT - REMEDIES**

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

- State Monitoring effective August 10, 2015. (42 CFR 488.422)

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

- Per instance civil money penalty of  for the deficiency cited at F323.  (42 CFR 488.430 through 488.444)

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

**SUBSTANDARD QUALITY OF CARE**

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care.  Therefore, Golden Livingcenter - Whitewater is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 17, 2015.  This prohibition remains in effect for the specified period even though substantial compliance is attained.  Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met.  Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

**APPEAL RIGHTS**

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

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

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

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

**ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 17, 2015 (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 January 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

**Mr. Patrick Sheehan, Supervisor**
**Health Care Fire Inspections**
**State Fire Marshal Division**
**444 Minnesota Street, Suite 145**
**St. Paul, Minnesota 55101-5145**
**Telephone: (651) 201-7205**

**Fax: (651) 215-0525**

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245270 | A. BUILDING _____ B. WING _____ | 07/17/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN LIVINGCENTER - WHITEWATER | 525 BLUFF AVENUE ST CHARLES, MN 55972 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.<br><br>A recertification survey was conducted by the Minnesota Department of Health on 7/13, 7/14, 7/15, 7/16 and 7/17/15. An extended survey was conducted on 7/16 and 7/17/15.<br><br>The survey resulted in an Immediate Jeopardy (IJ) at F323 due to the facility's failure to implement appropriate interventions including supervision, eating assistance and/or appropriate textured food/fluids in order to prevent choking/aspiration of fluid and foods for 2 of 2 residents (R12, R51) who had been identified as at risk.<br><br>The immediate jeopardy began on 7/13/15 when it was first observed the facility failed to provide the necessary supervision, needed assistance, and food consistency for R12 and/or R51 during meal service observations. The facility was notified of the IJ on 7/14/15 at 5:32 p.m. and was removed on 7/16/15, at 3:30 p.m. after the facility implemented a removal plan. However, non-compliance remained at the lower scope and | F 000 | | |

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

Electronically Signed | 08/14/2015

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

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| F 000 | Continued From page 1<br>severity level of a D, isolated, with no actual harm with a potential for no more than minimal harm. | F 000 | | |
| F 176 SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to conduct an assessment to determine whether a resident was capable to self administer medications for 1 of 1 resident (R8) reviewed for self administration of medication.<br><br>Findings Include:<br><br>R8's quarterly Minimum Data Set (MDS) assessment dated 6/9/15, identified the resident as having moderately impaired cognitive skills for daily decision making. In addition, the MDS indicated the resident's diagnoses included anxiety state. Current physician's orders identified on the July 2015 Medication Administration Record, included use of Miralax Powder (medication for constipation), give 1 scoop by mouth in the evening for constipation.<br><br>On 7/13/15 at 7:04 p.m. a cart with supper trays was observed to be taken from the kitchen by the activity director (AD)-A and registered nurse (RN)-B. Licensed practical nurse (LPN)-A stopped the supper tray cart and asked which tray | F 176 | F176<br>-R8 has had a self administration assessment completed to determine ability to self administer medications.<br>-Residents wishing to self administer medications have the potential to be affected if an assessment of their ability to safely self administer medications is not completed.<br>-Licensed staff have been educated on completion of self administration assessments prior to allowing self administration of medication.<br>-Random audits will be completed weekly on residents expressing a desire to self administer medications. Negative findings will be corrected immediately and reviewed at QAPI.<br>-DNS/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | 8/26/15 |

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| F 176 | Continued From page 2 | F 176 | | |

was for R8. LPN-A removed the chocolate milk from R8's supper tray and poured powdered medication from a medication cup into the chocolate milk. LPN-A verified she'd poured Miralax into R8's chocolate milk. LPN-A returned the chocolate milk to the supper tray and put the tray back into the cart. LPN-A then went back to the medication cart to proceed with passing medications for other residents. AD-A and RN-B continued towards the middle hall. After delivering R8 her supper tray at approximately 7:08 p.m., RN-B was heard to ask the administrator, "can you watch her? She has Miralax in that cup." RN-B returned at 7:13 p.m. and prompted R8 to drink her chocolate milk.

At 7:14 p.m. RN-B was questioned by the surveyor about whether or not R8 had been assessed to self administer the Miralax medication. R8 stepped away for a moment and immediately returned stating, "she has an order to self administer." When asked whether there had been an assessment of R8's ability to self administer the medication, RN-B stated, "I don't know, but I'll just take it away so you don't have to stand here." RN-B was then observed to take the chocolate milk from R8.

On 7/13/15 at 7:30 p.m. LPN-A was asked if it was routine practice to place Mirilax in R8's chocolate milk and send the tray to her room with whomever is delivering trays. "With her it is. She will not drink it if I bring it in. We have to do it that way. She just gets agitated when people watch her." When LPN-A was asked whether R8 had been assessed to self administer medications she stated, "I don't know, we just have to get creative to get her to take her meds."

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| F 176 | Continued From page 3<br>On 7/13/15 at 7:38 p.m. RN-A verified R8 did not have an assessment completed to identify R8's ability to self administer medications. RN-A also verified that it would not be normal practice to place medication into a resident's chocolate milk and send with the meal tray.<br><br>A Self Administration of Medications form completed for R8 on 2/10/14 indicated: Resident/patient request to self administer medications: 'No. No assessment completed.' The Interdisciplinary team (IDT) follow up date was 5/19/14, and was identified as a quarterly review. The note indicated 'No changes'.<br><br>The facility's policy: Medication Adminstation-General Guidelines, Section 7.2 dated 5/12 included: "B. Administration 5. The person who prepares the dose for administration is the person who administers the dose. 13. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications." | F 176 | | |
| F 225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>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 | F 225 | | 8/26/15 |

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| F 225 | Continued From page 4<br>other facility staff to the State nurse aide registry or licensing authorities.<br><br>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).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 5 of 5 new employees (E1, E2, E3, E4, E5) had reference checks completed as a part of their pre-hire screening. This had the potential to affect all residents in the facility.<br><br>Findings include:<br><br>E1 was hired by the facility as a registered nurse (RN) on 2/23/15. According to her human | F 225 | F225<br>-Reference checks have been completed on all new employees.<br>-All residents have the potential to be affected if reference checks are not completed and reviewed prior to employment.<br>-Hiring managers have been educated on requirements for reference checks on new hires prior to employment. | |

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| F 225 | Continued From page 5<br>resources (HR) file, E1 also began orientation 2/23/15. Upon review, it was noted the that although 1 work reference had been provided by the RN checks 1 work reference was listed, no documentation of attempted reference check, no response documented. One personal reference was provided, no documentation of attempted reference check, no response documented.<br><br>E2 was hired as a dietary staff 5/26/15. According to the HR file, a background study was requested on 5/26/15, however the provider had not received a documented final background study clearance to work. E2 began orientation on 5/26/15. Although a reference box in the file had been crossed off, there were no documented references.<br><br>E3 was hired and began orientation as a nursing assistant 6/23/15. According to the HR file, there was no documentation of a reference check (and the box 'may we contact' was not checked either yes or no). However the HR file indicated E3's termination from his previous employer was not voluntary. E3's file lacked the conditional offer of employment packet.<br><br>E4 was hired and began orientation as a dietary staff on 6/23/15. According to the HR file E4 had provided 2 work references, 1 educational reference, and 1 personal reference however there was no documentation that any references had been contacted prior to employment.<br><br>E5 was hired and began orientation as a dietary staff on 6/23/15. According to the HR file E5 had no documentation of a reference check prior to hire. | F 225 | -Audits of new hires will be completed to insure reference checks are completed prior to employment. Negative findings will be corrected immediately and reviewed at QAPI.<br>-ED/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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| F 225 | Continued From page 6<br>The facility's New Hire Orientation Workbook contained a new employee Personnel File Checklist. The form did not include a place to document when references were requested, and there were no other forms with documentation of who or when references were requested.<br><br>The facility's Conditional Offer of Employment packet included reference check pages, however they were either blank, or only had a name filled in but there was no documentation of when, or if, anyone had been contacted to provide a reference.<br><br>On 7/17/15, at 10:22 a.m. the executive director (ED) was interviewed and stated she was currently the person responsible for human resource questions. She was given the 5 new employee HR files reviewed for abuse prohibition. the ED verified that the reference checks were not completed. informed that 5 of 5 new employee files lack reference checks. | F 225 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, | F 280 | | 8/26/15 |

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| F 280 | Continued From page 7<br>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and document review, the facility failed to update the plan of care for 1 of 2 residents (R45) reviewed for falls.<br><br>Findings include:<br><br>R45 was discharged to the hospital on 6/4/15, readmitted on 6/16/15 with primary diagnoses of cerebral artery occlusion with infarct (stroke), hemiplegia affecting non-dominant side due to cerebral vascular disease (left sided weakness due to stroke). Upon readmission R45's care plan was not updated to reflect his current functioning status leading to a fall on 6/29/15.<br><br>R45's 14 day Minimum Data Set (MDS) dated 6/29/15 revealed R45 required an extensive two plus person physical assist for bed mobility, transfers, walking in room, personal hygiene, dressing and toilet use. Locomotion on and off the unit required an extensive one person physical assist. Functional limitation revealed impairment on one side for both upper and lower extremity.<br><br>The care plan provided was not correct and did not match the MDS and did not reflect the current need for assistance. Care plan dated 2/5/15, | F 280 | F280<br>-Plans of care has been updated for R45 for falls prevention.<br>-Residents with falls have the potential to be affected if care plans are not updated with new interventions.<br>-IDT has been educated on the requirements updating care plans.<br>-Audits of care plan updates will be conducted following resident falls to insure new interventions are reflected. Negative results will be reviewed at QAPI.<br>-DNS/designee will be responsible. Corrective action will be completed by 8/26/15. | |

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| F 280 | Continued From page 8<br>revision 5/29/15, indicated R45 was a one person assist to ambulate to/from the bathroom, independent mobility in room, and R45 should ambulate with nursing two to three times daily without assistive device and a stand by assist of one. The care giver guide was found not to match the care plan.<br><br>07/16/2015 10:34 a.m. Registered Nurse (RN)-A and the Director of Nursing (DON) verified care plan copy given to surveyor is most current care plan. Also verified the information on the care plan is conflicting, resident is not independent, and care plan has incorrect information. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the facility implemented physician orders to prevent edema for 1 of 1 resident (R33) reviewed who had a physician's order for antiembolism stockings.<br><br>Findings include:<br><br>R33's diagnoses were identified on the quarterly minimum data set (MDS) assessment to include: | F 309 | F309<br>-Physician orders for R33 have been reviewed and implemented as ordered.<br>-All residents have the potential to be affected if physician orders are not implemented when ordered.<br>-Nursing staff have been educated on following physician orders and process for requesting needed supplies. Facility has ordered an adequate supply of | 8/26/15 |

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| F 309 | Continued From page 9<br>congestive heart failure (CHF), hypertension (HTN), diabetes mellitus (DM), cerebrovascular accident (CVA), dementia and atrial fibrillation.<br><br>Review of R33's Physician's Orders And Signature Form revealed an order dated 7/7/15, which directed "Needs Tubigrips or Compression stockings on AM (morning), off PM (evenings) secondary to edema."<br><br>On 7/16/15, at 9:09 a.m. R33 was observed being wheeled down the hallway towards the desk by a family member (F1) who was at the facility visiting. R33 was observed wearing sweat pants, and he had on ankle socks and house slippers. At the time of the observation both of R33's ankles were uncovered and were noted to be swollen as F1 took him into his room. At 9:13 a.m. F1 was observed in R33's room helping to put the TV (television) on. Although R33 had visible swelling of the ankles, R33 was not wearing observed to be wearing the compression.<br><br>On 7/16/15, at 12:26 p.m. R33 was observed in the dining room (DR) seated in his wheelchair at the table eating lunch. R33 was not wearing either Tubigrips or the compression stockings at that time but was still wearing the ankle socks. R33's ankles remained swollen.<br><br>On 7/17/15, at 8:19 a.m. and again at 9:03 a.m., R33 was observed seated on his wheelchair at the DR table. R33 was not wearing compression stockings nor Tubigrips but was wearing black ankle socks. Both ankles were uncovered and were observed to be swollen.<br><br>On 7/17/15, at 8:20 a.m. registered nurse (RN)-D was interviewed about whether or not the order | F 309 | anti-embolism stockings for immediate use when ordered.<br>- Audits will be completed weekly to insure an adequate supply of anti-embolism stockings are available and residents requiring anti-embolism stockings are wearing them. Negative results will be reviewed at QAPI.<br>-DNS/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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dated 7/7/15, to apply Tubigrips or compression stockings for R33 was current. RN-D stated she would check after she was done with the breakfast medication pass.

On 7/17/15, at 8:57 a.m. the director of nursing (DON) stated she had talked to staff in the therapy department and learned that they had ordered the stockings. She further stated she had a staff person checking whether the stockings may have been sent to laundry. When asked if the stockings were sent to laundry daily the DON stated, "if they were soiled the staff would send them down because they aren't able to clean them in the sink."

On 7/17/15, at 9:03 a.m. nursing assistant (NA)-F stated, "For months he has not had TED (elastic) stockings. We can only tell the nurse the legs are swollen and we elevate them. I help him and have never seen them." NA-F verified R33's legs were swollen and stated R33 routinely wore ankle socks.

On 7/17/15, at 10:13 a.m. when asked who ordered the compression stockings RN-D stated the stockings would be ordered from the facility's own system and not from the pharmacy. RN-D indicated at the facility level there would be a person designated to make the orders the executive director or DON would be the ones to go in and accept the order placement. When asked whether the staff responsible for ordering the stockings was available, the ED stated the staff had called in sick for the day.

On 7/17/15, at 10:29 a.m. RN-D approached the surveyor and stated, "as we speak right now the Tubigrips are being applied and the compression

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| F 309 | Continued From page 11<br>stockings have been ordered." She acknowledged the order for the compression stockings had not been completed until now and verified R33 had swollen ankles.<br><br>On 7/17/15, at 11:29 a.m. the DON stated, "I would expect the order to be done and the stockings for this case to have been ordered and followed up to make sure they were delivered and applied. I expected the order to have been implemented." The DON acknowledged the compression stockings had not previously been ordered.<br><br>R33's care plan dated 3/20/14, indicated R33 had impaired cardiovascular status related to HTN and atrial fibrillation. The care plan directed staff to observe for, and report, signs of chest pain, edema, shortness of breath and to elevate the resident's lower extremities as indicated.<br><br>The facility's policy for Anti-embolism Stockings (Elastic Stockings), dated 2006, indicated the purpose of the stockings was to reduce edema, prevent embolus formation, to aid return circulation from lower extremities and to provide support to the lower extremities. | F 309 | | |
| F 323 SS=J | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. | F 323 | | 8/26/15 |

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| F 323 | Continued From page 12<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to implement appropriate interventions including supervision, eating assistance and/or appropriate textured food/fluids in order to prevent choking/aspiration of fluid and foods for 2 of 2 residents (R12, R51) who had been identified as at risk. The facility's failure to implement these interventions resulted in an immediate jeopardy situation for R12 and R51. The immediate jeopardy began on 7/13/15 when it was first observed the facility failed to provide the necessary supervision, needed assistance, and food consistency for R12 and/or R51 during meal service observations. The facility administrator, a corporate executive administrator, and a clinical services specialist from the corporate office were notified of the immediate jeopardy at 5:32 p.m. on 7/14/15. The immediate jeopardy was removed on July 16, 2015 but noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br>Findings include:<br>R12 and R51's medical records were reviewed. Speech language pathologist (SLP) and physician progress notes indicated the residents were at risk for choking and aspiration. According to R51's medical record, R51 had been treated for aspiration pneumonia as recently as 5/12/15. At the time of admission, R12 had been identified as having a diagnosis of dysphagia (difficulty swallowing). Although these resident's had specific interventions in place for supervision, assistance, and modified diets, the facility failed | F 323 | F323<br><br>-R12 and R51 were evaluated by speech therapy for proper diet and fluid consistency. . Recommendations for supervision while eating or drinking have been implemented, care planned, and are being followed.<br>-Residents at risk for aspiration have the potential to be affected if proper supervision is not provided while eating or drinking.<br>-Nursing staff have been educated on following therapy recommendations for supervision during meals. Licensed staff have been educated on signs/symptoms of aspiration and steps to take if aspiration suspected.<br>-Weekly audits will be conducted to review therapy recommendations for supervision are being implemented as written. Negative results will be reviewed at QAPI.<br>-Twice weekly audits for compliance over varied meals or snacks with varied staff involved for one month. Will review at QAPI to determine need to continue.<br>-DNS/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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to ensure these interventions were implemented consistently.
R12 was observed during the evening meal on 7/13/15, at 6:22 p.m. to sit at the dining room table independently drinking hot chocolate with no staff supervision. R12 was observed to begin to cough very loudly after a drink of the hot chocolate and the hot chocolate was observed to run out of his mouth. Nursing assistant (NA)-C, who had been passing out wipes to other residents in the dining room came over to R12, handed R12 a wipe and left the area. NA-C did not ask R12 if he was okay, or whether he was having difficulty swallowing the hot chocolate.
At 6:52 p.m. on 7/13/15, R12 again began to cough while eating. This time the cough was more violent and a pinkish/red colored liquid spewed from his mouth. There were no staff available in the immediate area, R12's face turned red as he continued to cough. Registered nurse (RN)-B came to the table about 2 minutes after the coughing had started and at 7:00 p.m., RN-B removed R12 (in his wheelchair) from the dining room while he continued to cough. R12 was taken out to the lobby. RN-B then re-entered the dining room and asked about what R12 had been served. RN-B stated the red apple sauce R12 had received was considered pureed fruit, and that the substance in the glass was a "thicker than pudding thick" fluid.
At 7:04 a.m., R12 was observed seated alone in the lobby at a small table against the wall. He had stopped coughing and his face color had returned to normal. R12 was noted to be facing towards the wall making him less easily visible by staff who might be in the area. RN-B had his food tray brought out and placed in front of him. Again R12 was left unsupervised with his meal. No staff were in the direct vicinity of R12, a licensed

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practical nurse (LPN)-A, was observed standing at a medication cart 15-20 feet away with her back to R12. At 7:11 p.m. R12 remained in the lobby area alone. A clinical psychologist (CP)-A was observed to approach R12 to remove his dinner tray at 7:13 p.m. At that time, the surveyor asked CP-A whether she'd had any formal training to assist residents with eating. CP-A stated she had not had any training for assisting residents to eat, but was removing the resident's tray because the surveyors were watching the resident.

During a breakfast meal observation on 7/14/15 at 9:03 a.m., R12 was observed to sit at the dining room table with his breakfast tray in front of him. There was no staff sitting with the resident or observed to be supervising the resident. R12 took a bite of cream of wheat, held it in his mouth for approximately 3 seconds and began to cough. Cereal was observed to drip out of his mouth and run down his chin. At 9:05 a.m. NA-C was observed to come over to R12 and whether he wanted a napkin. NA-C was heard to instruct R12 to "tuck and swallow." NA-C stayed at R12's table until 9:07 a.m. when she left R12's table and sat down at another table to feed a different resident. At 9:09 a.m. As R12 continued to eat his breakfast, he was observed to take several bites of food and hold it in his mouth for long periods of time before swallowing. R12 did not use the chin-tuck procedure while eating nor did staff monitor R12 while he was eating/chewing/swallowing or cue him to use the chin-tuck procedure. NA-C did not return to R12's table until 9:13 a.m.

During an interview on 7/14/15, at 9:24 a.m. Registered Dietician (RD)-A explained the baseline consistency for pureed food is applesauce, but verified the consistency of food

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and fluids for R12 should be pudding thick consistency. RD-A stated thickener should be added as needed to R12's food and fluid consistency was prepared as the physician had ordered. RD-A also stated, "people who have aspiration precautions, including R12, need direct supervision in the dining room."

During observation of lunch on 7/14/15 at 12:34 p.m., R12 sat at the table with a spoon in his mouth. No staff were present at the table or in direct view of R12 during this time. R12's meal tray included pureed carrots served at a honey thick consistency.
During an interview on 7/14/15 at 2:27 p.m., dietary assistant (DA)-A stated the dietary staff determined the consistency of R12's food by sticking a spoon in the food, and if the spoon stands straight up, it would be considered pudding thick. DA-A acknowledged she had served R12's carrots without having verified the consistency.
Following the facility's notification of the IJ, R12 was observed at 6:10 p.m. on 7/14/15 at the supper meal. R12 was seated at the dining table and was moaning loudly. RN-B was sitting between R12 and R51. R12 had attempted to take a heaping spoonful bite of cranberry juice. Although RN-B instructed R12 to take smaller bites, she did not instruct the resident to tuck his chin and swallow. Instead, R12 was observed to hold the cranberry juice in his mouth for approximately 7 seconds before swallowing. R12 took another bite that was smaller, chewed the bite, and was again observed to hold it in his mouth for several seconds. R12 took four more bites and each time held the food for several seconds in his mouth before swallowing. Throughout the observation, RN-B did not

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encourage R12 to use the chin-tuck technique. At 6:32 p.m. RN-B picked up R12's spoon and attempted to feed him. At 6:33 p.m. During the observation RN-B was also observed to assist R51 with eating. While RN-B was assisting R51, R12 resumed feeding himself. When RN-B returned to assist R12, she was observed to put food on the spoon and place bites in R12's mouth while there was still food in R12's mouth. R12 had food running out of his mouth, and was observed to hold food in his mouth at the same time. No instruction was provided for R12 to use chin-tuck then to swallow. At 6:39 p.m. R12 was observed to take a bite and to hold it in his mouth. R12 cried out "Ahh" and then began to cough. R12 then closed his mouth for a few seconds and when he opened his mouth again, a large amount of tan colored liquid drained out of his mouth onto his clothing protector. At 7:15 p.m. R12 was removed from the dining area and set in the lobby area.

During an interview with RN-B at 7:21 p.m. on 7/14/15, RN-B told the surveyor R12 had experienced a brief choking episode in the dining room. RN-B stated she and two nursing assistants had intervened. RN-B stated R12 had several bites of food in his mouth at the time. When the surveyor inquired, "How did he get that much food in his mouth?" RN-B stated, "He was eating right along and I thought he was swallowing but he didn't swallow. I was watching pretty close."

On 7/14/15, at 8:01 p.m. the director of nursing and administrator were informed of the concerns noted during the supper meal with R12.

During an observation of the breakfast meal on 7/15/15, at 8:20 a.m. R12 had been sitting at the dining room table with no staff member present at the table. Although R12 was served the correct

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consistency beverages, when R12 grabbed his spoon and attempted to remove a heaping bite of cranberry juice from the glass, RN-B walked by the table and only gave a verbal cue for R12 to take smaller bites. RN-B then walked away from the table without assisting R12 to take smaller bites of food, and without ensuring staff were present with R12 to supervise as he ate his meal. At 8:26 a.m. the surveyor brought to the attention of RD-A and RN-A that there was no one to supervise the resident as he attempted to eat the thickened drinks he had been served. At 8:27 a.m. RN-A was observed to sit down between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table ..." At 8:36 a.m. R12's meal was placed in front of him, and as he independently took a bite, he experienced a coughing incident. At that time, RN-A gave verbal cues to R12 to follow the chin tuck procedure. At 8:39 a.m. RN-A was observed to assist R51. At 8:41 a.m. NA-G sat down next to R51, however at 8:45 a.m. NA-G moved to the other side of the table to assist another resident, then walked away from the table to wash her hands. When NA-G left the table, RN-A also got up and moved to the other side of the table to assist the other resident leaving R12 without any assistance. NA-G returned to the table, however sat on the other side with her back to R12. After R12 had taken a couple of bites of food, copious amounts of saliva were observed to drain from his mouth. At that point the surveyor intervened and informed RD-A of the concern with R12 not being supervised while independently eating. RD-A got RN-B to sit with R12 at 8:58 a.m. until R12 had completed his meal.

R12 was admitted to the facility on 9/3/14 according to the facility admission record with

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diagnoses that included but were not limited to: dementia with behavioral disturbance, dysphagia (difficulty swallowing), esophageal reflux, central hearing loss, and anxiety disorder.
R12's quarterly Minimum Data Set (MDS) dated 5/26/15, indicated R12 had moderate cognitive impairment with a Brief Interview for Mental Status score of 10 which indicates confusion. The MDS indicated R12 had unclear speech, but responded adequately to simple direct communication. In addition, the MDS indicated R12 experienced coughing and/or choking during meals or when swallowing medication, and required staff supervision and assistance with eating and meal set up.
R12's quarterly nutrition assessment dated 6/12/15, indicated he had a swallowing disorder and required thickened liquids. The assessment included, "...Puree diet with pudding thick liquids, no white rice, no milk with meals ...r/t [related to] ongoing difficulties with swallowing..."
The record also indicated R12 had received speech therapy services from 2/18 through 5/6/15, for medical diagnoses of: cerebral vascular accident and treatment for dysphasia. Therapy notes indicated:
4/6/15- "R12 choked four times during the session, had delayed swallowing of 2-3 seconds." In addition, the note indicated education was given to staff on holding spoon in mouth for 2 seconds to elicit swallow, adding moisture to meats if needed, and providing smaller bites.
4/7/15- "education was given to staff to present food from the resident's right side and to use the spoon for liquids."
4/8/15-"required maximum (max) amount of verbal cues to use chin tuck, displayed anxiety related to coughing during meal, and one episode of coughing related to staff feeding too fast." In

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addition the treatment note read, "Pt [patient] does not appear to be a good candidate for self-feeding, at this time continue POC [plan of care] with increase in staff education to decrease risk of aspiration."
4/9/15- The note indicated R12 held medications in his mouth and required maximum verbal and visual cues to swallow. The note also indicated the resident had 3 coughing episodes and then became anxious.
The speech therapist orders dated 4/10/15, were communicated on a form entitled Rehab Recommendations and included: "Pureed diet with honey thick liquids, Patient [R12] must have staff sitting by him at meals, cue for patient to tuck chin on swallow, clear mouth prior to next bite, use a spoon for drinks, and take small bites (help with bite size as needed)."
On 4/13/15 speech therapy had changed the order from honey thick liquids to pudding thick liquids.
4/15/15 - "...education was given to staff for cuing compensatory strategies (these would include taking small bites and sips, alternate bites and sips, avoid slurping and drinking through straws, sitting upright, chin tuck also known as head flexion, etc.) to assist R12 in swallowing safely, R12 had increased coughing when he fed himself, and education was given to staff 'on need for increased supervision during meals' in case of aspiration or airway blockage."
4/23/15 - "...maximum anterior oral spillage. Coming out right side. Max pocketing on right side. Verbally walked him through swallow [technique]."
R12's care plan was provided by the facility on 7/14/15. The care plan indicated R12 had difficulty swallowing related to a cardiovascular accident. The care plan interventions included for

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staff to use the physician ordered diet of pureed with pudding thick liquids, no white rice, and no milk with meals. The care plan further instructed staff to "encourage to follow SLP [speech language pathologist] recommendations, monitor coughing during meals, eating assistance of 1, allow rsdt [resident] to attempt to feed self with staff assist as needed." The care plan had not been revised to include the SLP's specific recommendations identified on 4/10/15.

R51 was observed at 9:13 a.m. 7/14/15, during the breakfast meal to be sitting at the dining table eating his meal independently. R51 was observed to have honey thickened fluids, scrambled eggs and oatmeal. There was not a staff person at the table to supervise R51. R51 was observed to take a bite of oatmeal and to chew. Almost immediately R51 began to cough. R51 was observed to take another bite of oatmeal and again coughed several times. Facility staff in the dining room were assisting other residents and did not check on R51 when he had these coughing episodes. At 9:19 a.m. a nursing assistant, (NA)-C, first came to R51's table but did not intervene for R51, but assisted one of his tablemate's with eating.

During an evening meal observation on 7/14/15, at 6:13 p.m. R51 was observed seated at the dining room table drinking what appeared to be honey thickened hot chocolate. Registered nurse (RN)-B sat between R51 and R12. At 6:23 p.m. R51's food, which was observed to be the appropriate consistency, was placed in front of him. From 6:23 p.m. to 6:28 p.m. R51 ate independently without any verbal cues from RN-B. R51 was observed to take large bites, and to take additional bites before swallowing what

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was in his mouth. At 6:28 p.m. RN-B turned to face R51 and instructed R51 to take smaller bites. At that time R51 moved the food to center of R51's plate and removed food that had fallen into R51's lap with a fork, and placed it back onto R51's plate. At 7:01 p.m. R51 started to cough and his face turned red. RN-B instructed R51 he needed to stop coughing before taking another bite. R51 waited until the coughing had stopped then took a drink, and again coughed several times but did not turn red. At 7:08 p.m. R51 took another drink and again began coughing, however staff did not give any verbal cues to use the chin tuck procedure prior to swallowing.

At 7:11 p.m. on 7/14/15, the director of nursing (DON) brought R51 out of the dining room in his wheelchair and placed him in front of the television and gave him a tissue. R51 coughed twice, as the DON walked away. At 7:13 p.m. R51 was observed to start coughing again, and after approximately 30 seconds his face turned red, clear liquid drained from his mouth, and R51 used the tissue to wipe his face. The coughing ceased after R51 wiped his face.

During an interview with RN-B at 7:21 p.m. on 7/14/15, following the evening meal, RN-B stated, "...towards the end of the meal he [R51] started sputtering, so I patted him on the back and he coughed and got it out of his throat, so he's alright, you can hear it cleared." When asked how she could tell it had cleared, RN-B stated, "You can tell that he cleared it because you couldn't hear it gurgling anymore."

During an observation of the breakfast meal on 7/15/15, at 8:20 a.m. R51 was again observed sitting at the dining room with no staff members

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present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51.

At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m. R51's meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoonful of French toast. When R51 had put the bite in his mouth, RN-A who was also sitting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites." NA-G looked at R51 and told him to take smaller bites. At 8:45 a.m. NA-G moved away from R51 to assist his tablemate. R51 continued to eat independently without verbal cues. NA-G then walked away from the table to wash her hands. At the same time, RN-A got up and went to the other side of the table to assist R51's tablemate. When NA-G returned to the table, she sat at the opposite side from R51. At 8:58 a.m. RN-A continued to assist the tablemate (R12) with her back to R51. From 8:45 a.m. until 8:58 a.m. R51 was observed to eat independently, and was observed to take large amounts of food with each bite taken. At 8:58 R51 started coughing and his face turned red, RN-A suggested at that time that it would be good to "get a therapy referral for adequate chair positioning while eating."

R51's record was reviewed and the admission

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face sheet indicated R51 had been admitted to the facility on 11/5/13. In addition, according to the facility admission record, R51's diagnoses included: dysphagia, aspiration pneumonia, problems with swallowing and mastication (chewing), Parkinson's, dementia, and anxiety.

A Physician Visit note dated 5/12/15, indicated R51 had been seen that day because of a cough and low-grade temperature. The physician's exam revealed "crackles in right mid lung field and occasional expiratory wheeze." The physician documentation indicated R51 had been diagnosed with aspiration pneumonia, and had been prescribed Augmentin (an antibiotic) 875 milligrams (mg) twice a day for 7 days, and a nebulizer treatment for four days and as needed.

A nursing progress note dated 5/23/15 read, "...is able to fed [feed] self after set up, is at the feeder table for supervision. Eats slowly, is on nectar thick liquids."

R51's annual Minimum Data Set (MDS) dated 5/26/15, indicated R51 usually made self-understood however, had difficulty communicating some words or finishing thoughts, but was able if prompted and given time, to usually be understood by others. The MDS indicated R51 may miss some parts or intent of messages but comprehended most conversation. R51 was identified by the MDS to have a brief interview for mental status (BIMS) score of 11 which indicated mild cognitive impairment. The MDS further indicated R51 required limited physical assistance from one staff member for eating.

R51's nutritional assessment dated 6/19/15,

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identified a history of swallowing disorder. The assessment indicated the resident had a physician prescribed diet of mechanical soft with puree meets and vegetables with honey thick liquids, no added salt, no magic cups. The nutritional assessment summary note included, "...Resident has had some changes to diet d/t [due to] an occurrence [sic] of aspiration pneumonia in May [2015]...Resident is assisted at meal times now."

The record indicated R51 had received speech therapy from 3/3 through 4/17/15, to decrease signs and symptoms of penetration/aspiration, according to the Speech Therapy Progress and Updated Plan of Care form dated 3/3/15.

Speech therapy notes dated 3/19/15, included a written recommendation to change R51's diet from nectar thick liquids to honey thick liquids.

On 3/24/15 speech therapy had made an additional recommendation to change R51's diet to mechanical soft with pureed vegetables and meats, and honey thick liquids. The recommendation included, "Supervision needed at meals, make sure eggs are pureed not scrambled."

Speech therapy progress notes dated 4/17/15, indicated R51 utilized, "safe swallowing strategies with 90% accuracy with minimal verbal cues."

R51's care plan provided by the facility on 7/14/15, identified a problem area of swallowing difficulties related to dysphagia and aspiration pneumonia. The care plan interventions directed staff to provide a diet of honey thick liquids, puree meats and vegetables, no magic cups, and to

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provide assistance at meals as the resident would allow. In addition the care plan indicated R51 was to sit at the 'assisted dining table'. The care plan had not been revised to include the specific speech therapy recommendations identified on 3/24/15.

During an interview with dietary assistant (DA)-A at 2:27 p.m. on 7/14/15, DA-A stated she was not aware R51 was not supposed to have scrambled eggs, but should have received eggs of a pureed consistency and did not.

During an interview with NA-K on 7/14/15 at 2:15 p.m. she stated, "Usually every day there are just two [identified R12 & R51] that cough, [R12] more often that [R51] ....R51 does good on his own eating, I don't need to sit by him when he eats."

During an interview with NA-C on 7/14/15 at 2:15 p.m. she stated, "R12 needs and should get direct supervision- he needs to be told to tuck his chin and swallow, he holds food in his mouth, what is happening right now is there isn't enough staff members to feed 10 people so we have to basically go back and forth. There are only two aides in the dining room during meals, sometimes management will help during the day but not during the evening. A nurse might help pass trays but they never are in the dining room during the whole meal service." NA-C stated both R12 and R51 cough at every meal at least 3 to 4 times. NA-C explained R51 needed supervision and cueing then said, " He's not as bad as [R12] " in reference to coughing.

During an interview on 7/14/15 at 2:19 p.m., NA-H was asked about R12 and R51's coughing during meals. She stated often R12 and R51

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have coughing/choking episodes while eating. NA-H stated the coughing usually occurred because they both (R12 and R51) eat too fast.

During an interview on 7/14/15 at 7:15 p.m., NA-I stated she normally worked the evening shift and verified there are usually only two NA's in the dining room. NA-I stated a nurse might be able to help if they were done passing medications, but stated most of the time it is just the two aides.

During an interview on 7/14/15, at 7:21 p.m., NA-J stated she worked on the evening shift and that there are usually just two staff in the dining room to assist all of the residents that need assistance with eating. NA-J stated the nursing assistants have to move back and forth between the two tables. NA-J also stated R12 "likes to keep shoveling food in his mouth" and takes big bites and that is usually when food comes up. NA-J then explained prevention measures for R12 and R51 were to give verbal cues.

A facility policy Eating Support was reviewed and did not identify guidelines to assist residents who required changes to textured diets or supervision of residents who were at risk for choking and/or aspiration. A policy pertaining to aspiration precautions was requested, however on 7/17/15, at 9:56 a.m. RD-A and DON stated the facility did not have a policy.

The immediate jeopardy that began on 7/13/15, was removed on 7/16/15, when it was determined the facility had completed assessments for R12 and R51 to rule determine their aspiration risks, had revised the residents' care plans to include current speech therapy recommendations, it was verified staff had been re-educated to understand

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| F 323 | Continued From page 27<br>the importance of supervision of the residents during meals, and had been re-educated to resident specific interventions for prevention of aspiration, and observation of a meal reflected appropriate implementation of interventions. However, noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm due to the facility's population including residents with swallowing difficulty. | F 323 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | F 329 | | 8/26/15 |

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| F 329 | Continued From page 28<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement and document non-pharmalogical interventions prior to using as needed (PRN) medications for behavioral outbursts or pain, for 3 of 5 residents (R8, R41 and R22) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R8's most recent physician order sheets signed and dated 7/7/15, revealed that R8 had orders for the following psychoactive medications: Ativan (anxiety medication) 0.5 milligrams (mg), apply to pulse areas topically every 4 hours as needed for anxiety, and to apply Ativan gel to pulse areas.<br><br>R8's Medication Administration Record revealed:<br>On 7/3/15, Ativan 0.5 mg was administered topically for anxiety. No documentation of behavior.<br>On 5/14/15; 5/23/25 (no documentation of behavior) Ativan 0.5 mg was administered topically for anxiety, and on 5/29/15, no behavior documentation on that day, Ativan 0.5 mg was administered topically for anxiety.<br>On 4/15/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety.<br>On 1/10/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety.<br><br>In addition, there was no documentation on the medication administration record (MAR) that | F 329 | F329<br>-Non-pharmacological interventions are being implemented and documented prior to administration of prn medications for R8, R41, and R22.<br>-Residents receiving prn medications have the potential to be affected if non-pharmacological interventions are not identified, attempted, and documented prior to administration.<br>-Licensed nursing staff have been educated on the requirement to offer and document non-pharmacologic interventions and effectiveness prior to administration of prn medications.<br>-Two to three weekly audits for 30 days will be conducted of prn administration of medications to ensure the documentation of non-pharmacological interventions and the results of these interventions prior to administration of prn medications. Negative results will be reviewed at QAPI and action planned as needed. Results to be reviewed at QAPI to determine further contination.<br>-DNS/Designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.

R8's nurses' notes were reviewed from 8/3/14-7/12/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R8's ativan.

A review of the nursing assistant care sheets for R8 for the past year also revealed there had been no direction provided for the nursing assistants to attempt non-pharmalogical interventions for R8's behaviors.
R41's most recent physician order sheets signed and dated 7-9-17 (error in date) revealed that R41 had orders for the following psychoactive medications: Ativan Solution (antianxiety medication), Apply to pulse regions topically as needed for anxiousness and agitation, Supplied in 1 mg/ml individual syringe dose. Apply 0.5 ml topically to pulse points as needed. Cover with a Tegaderm if the resident is rubbing the medication off.

R41's Medication Administration Records revealed:
a. On 4/3/15 - Ativan Solution 0.5 milliliters (ml) was administered for anxiety and
b. On 5/15/15; 5/24/15; Ativan Solution 0.5 ml was administered for anxiety. There was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan Solution for R41.

R41's nurses' notes were reviewed from 4/3/15 to 5/24/15 and revealed no documentation to

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| F 329 | Continued From page 30<br>indicate that non-pharmacological interventions were attempted prior to the administration of R41's psychoactive medication.<br><br>On 7/16/15 at 1:13 p.m. the DON stated non-pharmacological interventions should be attempted prior to administration of the PRN medications. The DON stated the interventions should be documented in the progress notes or behavior charting. The DON confirmed there was no documentation of non-pharmacological interventions on 4/3/15, 5/15/15, or 5/24/15 (dates when R41 received PRN ativan).<br>R22 was admitted to the facility on 12/29/14 according to the facility admission record with diagnoses that included but was not limited to rheumatoid arthritis, abscess of anal and rectal regions, malignant neoplasm intestinal tract, perforation of intestine, osteoporosis, muscle weakness, pathological fracture of a vertebrae, obesity, and chronic pain.<br>R22's quarterly Minimum Data Set (MDS) dated 6/30/15 indicated no cognitive impairment with a Brief Interview for Mental Score (BIMS) score of 15 and required extensive assist from staff to complete activities of daily living. The MDS further indicated the resident received scheduled pain medication and utilized as needed pain medication.<br>R22's care plan provided by the facility on 7/14/15 informed staff of the need for pain management related to: osteoporosis and rheumatoid arthritis. The care plan directed staff to administer pain mediation as ordered, identify items/activities that could serve to distract pain, evaluate the need for routinely scheduled medications rather than PRN pain medication administration, evaluate the need to provide medications prior to treatment or therapy, implement the patient's preferred | F 329 | | |

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| F 329 | Continued From page 31 | F 329 | | |

non-pharmacological pain relief strategies (rest, repositioning, movement to a quiet environment)
R22's physician orders provided by the facility on 7/15/15 included the following PRN (as needed) pain medication: Tylenol 650 milligrams (mg) by mouth every six hours as needed for pain and restlessness, and Dilaudid 2 mg by mouth every 2 hours as needed for pain between 2:00 p.m. and 2:00 a.m.
R22's medication administration records (MAR) were reviewed from June 1,2015 through July 14, 2015.
The June MAR indicated R22 was administered PRN Tylenol three times total and that it had been used in combination with the PRN Dilaudid; records indicated the Tylenol was administered prior to the PRN Dilaudid. However, the MAR indicated the Tylenol had not been administered after 6/7/15. The MAR indicated PRN Dilaudid had been administered a total of 56 times in June; 53 doses were administered without prior dosing of Tylenol or in combination with Tylenol. It was not evident in the medical record Tylenol was offered for R22 prior to administration of PRN Dilaudid. It was also not evident in the medical record non-pharmacological interventions were attempted prior to administration of Dilaudid for any of the doses administered.
July's MAR indicated no use of the PRN Tylenol and PRN Dilaudid was administered 13 times. It was not evident in the medical record non-pharmacological interventions were attempted prior to the administration of PRN Dilaudid for any of the doses administered.
R22's nursing progress notes were also reviewed for June and July, the majority of the progress notes simply indicated the PRN pain medication that was administered, the intensity of the pain using a 0-10 pain scale, if the pain medication

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| F 329 | Continued From page 32<br>was "effective" or "ineffective." The progress notes lacked a pain assessment/evaluation that would include location and characteristics or description of the pain.<br>During an interview on 7/16/15 at 11:18 a.m., the director of nursing (DON) verified the absence of documentation of non-pharmacological intervention prior to the administration of PRN pain medication. The DON stated her expectation was that staff would fully document a pain evaluation which would include the use of non-pharmacological interventions and the outcome.<br>The facility's policy Medication Monitoring and Medication Management, last revised November 2011, did not reflect current standards for use of non-pharmacological interventions prior to use of PRN medications. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure the consultant pharmacist identified lack of irregularities for | F 428 | F428<br>-Consultant pharmacist has reviewed medication regimen for R8, R41, and R22 | 8/26/15 |

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| F 428 | Continued From page 33<br>non-pharmacological interventions utilized prior to administration of as needed (PRN) medications for behavioral outbursts for 3 of 5 residents (R8, R41 & R22) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R8's most recent physician order sheets signed and dated 7/7/15, revealed that R8 had orders for the following psychoactive medications: Ativan (anxiety medication) 0.5 milligrams (mg), apply to pulse areas topically every 4 hours as needed for anxiety, and to apply Ativan gel to pulse areas.<br><br>R8's Medication Administration Record revealed:<br>On 7/3/15, Ativan 0.5 mg was administered topically for anxiety. No documentation of behavior.<br>On 5/14/15; 5/23/25 (no documentation of behavior) Ativan 0.5 mg was administered topically for anxiety, and on 5/29/15, no behavior documentation on that day, Ativan 0.5 mg was administered topically for anxiety.<br>On 4/15/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety.<br>On 1/10/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety.<br><br>In addition, there was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.<br><br>R8's nurses' notes were reviewed from 8/3/14-7/12/15 and revealed no documentation to | F 428 | for irregularities.<br>-Residents receiving medications have the potential to be affected if irregularities in medication regimen are not identified.<br>-Consultant pharmacist has reviewed medications for all residents and is making recommendations when irregularities are identified.<br>-Consultant pharmacist report will be reviewed monthly to insure irregularities are identified. Negative results will be reviewed at QAPI.<br>-DNS/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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indicate that non-pharmacological interventions were attempted prior to the administration of R8's ativan.

A review of the nursing assistant care sheets for R8 for the past year also revealed there had been no direction provided for the nursing assistants to attempt non-pharmalogical interventions for R8's behaviors.
R41's most recent physician order sheets signed and dated 7-9-17 (error-was to be 7/9/15) revealed that R41 had orders for the following psychotropic medications: Ativan Solution (antianxiety medication), Apply to pulse regions topically as needed for anxiousness and agitation, Supplied in 1 mg/ml individual syringe dose. Apply 0.5 ml topically to pulse points as needed. Cover with a Tegaderm if the resident is rubbing the medication off.
Review of R41's Medication Administration Record (MAR) revealed as follows:
a. On 4/3/15 - Ativan Solution 0.5 milliliters (ml) was administered for anxiety and
b. On 5/15/15; 5/24/15; Ativan Solution 0.5 ml was administered for anxiety. There was no documentation on the MAR that non-pharmacological interventions were attempted by staff prior to administering the Ativan Solution to R41.

R41's nurses' notes were reviewed from 4/3/15 to 5/24/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R41's antipsychotic medication.

On 7/16/15 at 1:13 p.m. the DON stated non-pharmacological interventions should be attempted prior to administration of the PRN

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| F 428 | Continued From page 35 | F 428 | | |

medications. The DON stated the interventions should be documented in the progress notes or behavior charting. The DON confirmed there was no documentation of non- pharmacological interventions on 4/3/15, 5/15/15, or 5/24/15 for R41.

On 7/16/2015 5:58 p.m. the consultant pharmacist (CP)-A stated documentation of attempted non-pharmacological interventions should be completed in residents' medical record for the use of PRN medications.

On 7/17/15 at 7:05 a.m. CP-A stated he had spoken to his supervisor and monitoring for non-pharmacological interventions prior to using PRN medications was not part of the monthly pharmacy review.
The Clinical Pharmacist Services Agreement commencing on August 26, 2014 read, "...1. Scope of Services...1.2 perform a comprehensive medication regimen review ("MRR") of each Facility Patient at least once a month and report in writing any irregularities, deviations, or unusual occurrences to Facility's Executive Director, Medical director, Director of Nursing and/or, where appropriate, to the Patient's attending physician; 1.3 review the drug regimen of each Facility Patient at least once a month and report in writing any irregularities, deviations or unusual occurrences..."
R22 was admitted to the facility on 12/29/14 according to the facility admission record with diagnoses that included but was not limited to rheumatoid arthritis, abscess of anal and rectal regions, malignant neoplasm intestinal tract, perforation of intestine, osteoporosis, muscle weakness, pathological fracture of a vertebrae, obesity, and chronic pain.

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| F 428 | Continued From page 36<br>R22's quarterly Minimum Data Set (MDS) dated 6/30/15 indicated no cognitive impairment with a Brief Interview for Mental Score (BIMS) score of 15 and required extensive assist from staff to complete activities of daily living. The MDS further indicated the resident received scheduled pain medication and utilized as needed pain medication.<br>R22's care plan provided by the facility on 7/14/15 informed staff of the need for pain management related to: osteoporosis and rheumatoid arthritis. The care plan directed staff to administer pain mediation as ordered, identify items/activities that could serve to distract pain, evaluate the need for routinely scheduled medications rather than PRN pain medication administration, evaluate the need to provide medications prior to treatment or therapy, implement the patient's preferred non-pharmacological pain relief strategies (rest, repositioning, movement to a quiet environment)<br>R22's physician orders provided by the facility on 7/15/15 included the following PRN (as needed) pain medication: Tylenol 650 milligrams (mg) by mouth every six hours as needed for pain and restlessness, and Dilaudid 2 mg by mouth every 2 hours as needed for pain between 2:00 p.m. and 2:00 a.m.<br>R22's medication administration records (MAR) were reviewed from June 1,2015 through July 14, 2015.<br>The June MAR indicated R22 was administered PRN Tylenol three times total and that it had been used in combination with the PRN Dilaudid; records indicated the Tylenol was administered prior to the PRN Dilaudid. However, the MAR indicated the Tylenol had not been administered after 6/7/15. The MAR indicated PRN Dilaudid had been administered a total of 56 times in June; 53 doses were administered without prior | F 428 | | |

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| F 428 | Continued From page 37<br>dosing of Tylenol or in combination with Tylenol. It was not evident in the medical record Tylenol was offered for R22 prior to administration of PRN Dilaudid. It was also not evident in the medical record non-pharmacological interventions were attempted prior to administration of Dilaudid for any of the doses administered.<br>July's MAR indicated no use of the PRN Tylenol and PRN Dilaudid was administered 13 times. It was not evident in the medical record non-pharmacological interventions were attempted prior to the administration of PRN Dilaudid for any of the doses administered.<br>R22's nursing progress notes were also reviewed for June and July, the majority of the progress notes simply indicated the PRN pain medication that was administered, the intensity of the pain using a 0-10 pain scale, if the pain medication was "effective" or "ineffective." The progress notes lacked a pain assessment/evaluation that would include location and characteristics or description of the pain.<br>During an interview on 7/16/15 at 11:18 a.m., the director of nursing (DON) verified the absence of documentation of non-pharmacological intervention prior to the administration of PRN pain medication. The DON stated her expectation was that staff would fully document a pain evaluation which would include the use of non-pharmacological interventions and the outcome.<br>The facility's policy Medication Monitoring and Medication Management, last revised November 2011, did not reflect current standards for use of non-pharmacological interventions prior to use of PRN medications. | F 428 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS | F 441 | | 8/26/15 |

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| F 441 | Continued From page 38<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | | |

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| F 441 | Continued From page 39<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to establish an infection control program that included consistent monitoring of symptoms and type of infection, tracking of causal organisms and symptom resolution of infections. In addition, the facility failed to ensure a soiled isolation linen cart receptacle was not overflowing in R22's room; and failed to ensure appropriate clean technique was used when changing an indwelling catheter collection bag for R12. The facility's failure to establish an infection control program had the potential to affect all 45 residents who resided in the facility.<br><br>Findings include:<br><br>LACK of INFECTION CONTROL PROGRAM:<br><br>Facility Line Listing of Resident Infections flow sheet from 1/2015 to 6/2015 was reviewed. The flow sheet identified the following information which was to be collected by the infection control coordinator: Room, unit, resident name, admission date, type of infection, symptoms/date, cultures, treatment, other actions (if needed), and HAI (Healthcare Associated Infection) or CAI (Community Acquired Infection).<br><br>Document review Line Listing of Resident Infections flow sheet revealed the following:<br><br>1/2015, twelve residents in the facility had experienced possible infections. Eleven of the twelve residents had actual symptoms identified (i.e. increased urinary incontinence, cough, elevated temperature). Eleven of the twelve residents had type of infection identified. All | F 441 | F441<br>-Facility infection control program includes monitoring of organisms and resolution of infections. Clean technique is being used when changing indwelling catheter collection bag for R12. Linen receptacle has been removed from R22¿s room.<br>-All residents have the potential to be affected if infection control practices are not consistently followed.<br>-All staff have been educated on infection control program. Nursing staff have been educated on proper procedure for infection control when changing catheter collection bags. DNS has been educated on infection control tracking.<br>-Random audits will be completed weekly of infection control measures during catheter collection bag changes. Facility infection control program will be reviewed monthly to insure monitoring of organisms and resolution of infections is included. Negative findings will be reviewed at QAPI.<br>-DNS/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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twelve residents had antibiotic identified. None of the twelve residents had causal organisms identified. None of the twelve residents had symptom resolution identified.

2/2015, eight residents in the facility had experienced possible infections. Six of the eight residents had actual symptoms identified. All eight of the residents had type of infection identified. All eight residents had antibiotic identified. One of the eight residents had causal organisms identified. None of the eight residents had symptom resolution identified.

3/2015, Ten residents in the facility had experienced possible infections. Six of the ten residents had actual symptoms identified. Nine of the ten residents had type of infection identified. All ten residents had antibiotic identified. None of the ten residents had causal organisms identified. None of the ten residents had symptom resolution identified.

4/2015, Eleven residents in the facility had experienced possible infections. Seven of the eleven residents had actual symptoms identified. All eleven of the residents had type of infection identified. All eleven residents had antibiotic identified. None of the eleven residents had causal organisms identified. None of the eleven residents had symptom resolution identified.

5/2015, Eleven residents in the facility had experienced possible infections. Nine of the eleven residents had actual symptoms identified. Ten of the eleven residents had type of infection identified. Nine of the eleven residents had antibiotic identified. None of the eleven residents had causal organisms identified. None of the

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| F 441 | Continued From page 41<br>eleven residents had symptom resolution identified.<br><br>6/2015, Partial listing of infections was provided. Three residents in the facility had experienced possible infections. Two of the three residents had actual symptoms identified. Two of the three residents had type of infection identified. All three residents had antibiotic identified. None of the three residents had causal organisms identified. None of the three residents had symptom resolution identified.<br><br>The facility's policy, Infection Control Program dated 4/6/15 included: "An infection control program designed to provide and maintain a safe, sanitary and comfortable work environment and to help prevent the development or transmission of disease or infection will be established for all facilities." Although requested, there was no further policy provided related to components of the infection control program.<br><br>During interview on 7/15/15, at 1:30 p.m. registered nurse-A (RN-A), stated she was responsible for the facility's infection control program. RN-A verified the facility Line Listing of Resident Infections was the facility's monitoring system for infections. RN-A verified monitoring from 1/2015 to 6/2015, lacked consistent monitoring of symptoms and type of infections. RN-A verified the infection control program lacked identification of causal organisms and lacked symptom resolution of infections.<br>LACK of PROPER Handling and Storage of Isolation Linens:<br>R22 was observed on 7/13/15, at 3:29 p.m. R22 had isolation containers in her room located up-against the wall. The lid of the linen container | F 441 | | |

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| F 441 | Continued From page 42 | F 441 | | |

was ajar with soiled linens touching two pillows that had been sitting on top of chair adjacent to the container. NA-F had a covered clean linen cart outside of R22's room. NA-F came into the room. When asked about the overfull container, NA-F responded by explaining "that is an infection control issue," she further explained the linens should have been removed from the room. NA-F then stripped the pillow cases off the pillow without putting gloves on, touched the lid of the container to open it, touched the linens inside the container, and then walked outside of the room without washing her hands and touched the outside of the cover of the linen cart to pull the cover down over the clean linens. NA-F used the hand sanitizer located outside the resident's room and came back in the room and put gloves on. NA-F completed the removal of the linens using standard infection control practices.
During an interview on 7/16/15, at 3:37 p.m. DON stated R22 had VRE (Vancomycin Resistant Enterococcus) in an open wound that was now healed on her abdomen and was unsure if the VRE was in her ostomy. DON explained plan to call nurse practitioner (NP) to inquire if isolation precautions could be removed. DON stated NA should have washed her hands and donned gloves prior to handling the pillow cases and touching the linen on the inside of the container, NA should have then taken off her gloves and washed her hands prior to leaving the room.

The facility provided guidelines for personal protective equipment for isolation circumstances, the guidelines directed staff to wash hands and use gloves.

A policy on storage and transportation of soiled isolation linen was requested and not received.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245270 | A. BUILDING _____ B. WING _____ | 07/17/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN LIVINGCENTER - WHITEWATER | 525 BLUFF AVENUE ST CHARLES, MN 55972 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 441 | Continued From page 43<br><br>Urinary Catheter<br>During an observation of activities of daily living on 7/14/15, at 1:02 p.m. R12 was sitting on the toilet, nursing assistant (NA)-C explained urinary catheter collection bag had a hole in it and she was going to change it. NA-C removed the end cap from the new urinary collection bag tubing and draped the new tubing over the mechanical lift that had been in the bathroom, struggled to remove a connection piece on the actual Foley catheter. After the piece had been removed, NA- used an alcohol wipe to clean the end, NA-C then touched the floor with her right hand and with soiled gloves touched R12's clothing. NA-C did not remove her gloves or wash/sanitize her hands. NA-C proceeded to pick up the end of the tubing of the collection bag. NA-C then was going to connect the contaminated end of the collection bag. NA-C was stopped by surveyor before the new sterile tubing was connected, and a new collection bag was obtained.<br>R12's quarterly Minimum Data Set (MDS) dated 5/26/15 indicated moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 10, had a diagnoses of dementia, and had an indwelling Foley catheter.<br>During an interview on 7/16/15, at 3:37 p.m. director of nursing (DON) explained the NA should have taken off gloves and washed hands and donned new gloves after touching the floor and the resident's clothes and the collection bag tubing should not have been draped over the mechanical lift.<br>The facility provided policy Catheter (Indwelling) Insertion and Removal of (Female and Male) that was last reviewed 1/26/15, the policy did not include direction on changing urine collection bags. | F 441 | | |

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| GOLDEN LIVINGCENTER - WHITEWATER | 525 BLUFF AVENUE ST CHARLES, MN 55972 |

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| F 465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure lift sheets were maintained in proper repair and were kept clean. This had the potential to affect 11 of 11 residents residing in the facility who utilized the shared lift sheets.<br><br>Findings included:<br><br>On 7/7/15, at 9:00 a.m. a transfer lift was observed parked in the hallway on the 100 Wing. Hanging on top of the lift was a blue lift sheet which was observed to be soiled with multiple brown, white and green stains. In addition the mesh cloth attached underneath the the lift sheet, was observed to be torn off and the ripped mesh was hanging loose.<br><br>On 7/16/15, at 9:30 a.m. another transfer lift machine was observed stationed in mid-hallway of the 300 Wing. The blue lift sheet was observed to be soiled with brown and white spots on the lift sheet.<br><br>On 7/16/15, at 12:30 p.m. to 12:47 p.m. during the environmental tour with the maintenance manager (MM) he verified both the lift sheets for the Sit to Stand lifts were not clean. When asked what the brown, white and green spots/marks | F 465 | F465<br>-All lift sheets have been inspected for potential replacement and properly cleaned. Lift sheets noted to need repair have been replaced.<br>-Residents requiring assistance of a mechanical lift to transfer have the potential to be affected if lift sheets are not kept in proper repair and properly cleaned. Lift sheets will be checked monthly for need of repair and replaced if repair needed. Lift sheets will be laundered weekly and more often if they are soiled.<br>- Nursing staff have been educated on checking lift sheets for soiling or need of replacement including necessary steps to be taken.<br>-Weekly audits of lift sheets to inspect for damage or soiling will be conducted for lift sheets being used by multiple residents. Negative findings will be addressed immediately and reviewed at QAPI.<br>-Maintenance director/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | 8/26/15 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 465 | Continued From page 45 | F 465 | | |

were MM was not able to indicated and stated when they were dirty laundry department would clean them. When asked how often the lift sheets were cleaned MM stated he was not sure. MM further stated the facility currently had two Sit to Stand transfer lifts as one had gone down recently.

On 7/16/15, at 12:53 p.m. the director of nursing (DON) verified the lift sheet in the Sit to Stand transfers lift in the 100 Wing was soiled and was with ill repair. When asked what her expectation was of staff DON stated she expected staff to send the lift sheets to laundry for cleaning when they noticed it was not clean. In addition the DON stated she would have expected the staff to report to her the lift sheet was in ill repair but indicated she had been out of the facility and was not sure if the lift sheet had been ordered. DON further stated the lift sheets were shared amongst residents in the facility.

On 7/16/15, at 1:55 p.m. the MM approached the surveyor and stated he had found out the lift sheets were cleaned as needed and would be sent down to laundry when dirty.

On 7/16/15, at 5:11 p.m. registered nurse (RN)-A approached the surveyor to provide names of residents that shared the Sit to Stand transfer lift and the manual lift. When asked whether there was a cleaning schedule for when the shared lift sheets were cleaned, RN-A stated there was no schedule and stated the lift sheets were supposed to be cleaned when dirty. RN-A acknowledged the lift sheets were shared and needed to be kept clean as they went from room to room.

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| | 245270 | A. BUILDING _____ B. WING _____ | 07/17/2015 |

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| F 465 | Continued From page 46<br>On 7/16/15, at 5:30 p.m. a Sit to Stand transfer lift was observed stationed by the fire door in the 100 Wing outside room 104 and the lift sheet which was hanging on top of the machine was still observed to be soiled even though the concern had been brought to the facility's attention. | F 465 | | |
| F 497 SS=F | 483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE<br><br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 5 of 6 nursing assistants (NA-A, NA-B, NA-C, NA-D, and NA-E) received annual performance reviews. This had the potential to impact all 45 residents in the facility which was a one story facility where staff work on all of the units.<br><br>Findings included:<br><br>NA-A's personnel file revealed a hire date of | F 497 | F497<br>-Annual performance reviews have been completed for nursing assistants. Continuing education hours for staff that have worked at the facility greater than 12 months has been completed.<br>-All residents have the potential to be affected if performance evaluations and continuing education are not provided for staff.<br>-Department managers have been | 8/26/15 |

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| | 245270 | A. BUILDING _____ B. WING _____ | 07/17/2015 |

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| F 497 | Continued From page 47<br>10/29/08. The director of nursing (DON) verfied during interview on 7/17/15 at 8:35 a.m., that there had been no annual performance evaluations completed for NA-A.<br><br>NA-B's personnel file revealed a hire date of 1/7/13. The DON verified during interview on 7/17/15 at 8:41 a.m., that there had been no annual performance evaluation completed for NA-B since hire.<br><br>NA-C's personnel file revealed a hire date of 9/23/13. During interview with the DON on 7/17/15 at 8:44 a.m., the DON verified there had been no annual performance evaluations completed for NA-C.<br><br>NA-D's personnel file revealed a hire date of 10/4/13. During interview with the DON on 7/17/15 at 8:48 a.m., the DON verified there were no performance evaluations available for the employee.<br><br>NA-E's personnel file revealed a hire date of 6/27/05. The DON verified during interview on 7/17/15 at 8:51 a.m., that there had been no annual performance evaluation completed for NA-E in the past year.<br><br>On 7/16/15, at 5:33 p.m. the facility's NA trainer stated as far as he was aware all the information availabe for the nursing assistants had been provided. At 5:36 p.m. registered nurse (RN)-D stated all the in-service training listed in the hand written papers were each equivalent to an hour.<br><br>On 7/17/15, at 8:54 a.m. DON stated she would be the one to do nursing department performance evaluations but had started her current position | F 497 | educated on completing annual performance reviews and required annual training for employees.<br>-Random audits will be completed monthly on performance reviews and continuing education needs. Performance reviews and required annual training will be completed timely. Negative results will be reviewed at QAPI.<br>-DNS/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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| F 497 | Continued From page 48<br>only seven months ago.<br><br>On 7/17/15 at 9:27 a.m., the executive director (ED) stated her expectation was for the facility to be in compliance with the regulatory requirements.<br><br>On 7/17/15 at 10:43 a.m., RN-D approached the surveyor and stated the facility did not have a performance review policy but would be expected to follow the regulatory requirements. | F 497 | | |
| F 520 SS=F | 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. | F 520 | | 8/26/15 |

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| F 520 | Continued From page 49<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to have the required members attend the Quality Assessment and Assurance Committee (QAA) at least quarterly. This deficient practice had the potential to affect all 45 residents who resided in the facility at the time of the survey.<br><br>Findings include:<br><br>Review of the facility's QAA meeting attendance record reviewed from 7-30-14 to 4-15-15 revealed the medical director attended the QAA meetings on 7-30-14, 10-15-14 and 4-15-15. The attendance record revealed no physician attended the QAA meeting held on 1-2-15.<br><br>On 07/17/2015 9:17 a.m. the director of nursing (DON) stated based on the documentation of meeting attendance for QAA meetings the medical director (MD) did not attend quarterly meetings in the last year. The DON verified the attendance records reflected MD had not attended the 1/2/15 quarterly review meeting. | F 520 | F520<br>-QAA meetings are being held at least quarterly.<br>-All residents have the potential to be affected if QAA meetings are not held at least quarterly to identify areas for improvement.<br>-Department managers have been educated in QAA requirements.<br>-Monthly audits will be conducted to insure QAA meetings are held per CMS requirements with the required attendees.<br>-Physician educated on 8/13/15 in regards to quarterly QAA attendance regulation.<br>-Physician will attend QAA at least quarterly via telephone conference or in person.<br>-ED/designee will be responsible.<br>-Corrective action will be completed by 8/26/15. | |

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| | 245270 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/14/2015** |

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| **GOLDEN LIVINGCENTER - WHITEWATER** | **525 BLUFF AVENUE**<br>**ST CHARLES, MN 55972** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Living Center Whitewater was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145 | K 000 | EPOC | |

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

Electronically Signed | 08/14/2015

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

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| K 000 | Continued From page 1<br>St Paul, MN 55101-5145, or<br><br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Golden Living Center Whitewater is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1967, with a partial basement and was determined to be of Type II(111) construction. In 1969, an addition was constructed to the West Wing that was determined to be of Type II(111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.<br><br>The building is fully sprinklered. The facility has a fire alarm system with 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 46 at the time of the survey. | K 000 | | |

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| | 245270 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **07/14/2015** |

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| K 000 | Continued From page 2<br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 018 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. The deficient practice could affect 15 out of 46 residents.<br><br>Findings include:<br><br>On facility tour between 0745 AM and 10:30 AM | K 018 | K018: The maintenance director has added an additional electronic preventative maintenance procedure that will advise him to check all doors for proper closure of shutting and latching. This task will ask to have this done on a monthly basis. Doing this will ensure that all doors in the facility will consistently shut and latch to provide resident and staff safety. | 8/31/15 |

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| K 018 | Continued From page 3<br>on 07/14/2015, it was observed that the kitchen - SW door, open to corridor will not shut/ and latch.<br><br>This deficient practice was confirmed by the Facility Maintenance Director (JM) at the time of discovery. | K 018 | | |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 5 out 46 residents.<br><br>Findings include:<br><br>On facility tour between 0745 AM and 10:30 AM on 07/14/2015, observation revealed, that the basement - storage room # 3 (over 50 sq.ft.) will | K 029 | K029: The maintenance director has added an additional preventative maintenance procedure that will advise him to check all doors for proper closure of shutting and latching. This task will ask to have this done on a monthly basis. Doing this will ensure that all doors in the facility will consistently shut and latch to provide resident and staff safety. | 8/31/15 |

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| | 245270 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **07/14/2015** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **GOLDEN LIVINGCENTER - WHITEWATER** | **525 BLUFF AVENUE**<br>**ST CHARLES, MN 55972** |

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| K 029 | Continued From page 4<br>not shut and latch<br><br>This deficient practice was confirmed by the Facility Maintenance Director (JM) at the time of discovery. | K 029 | | |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 46 residents.<br><br>Findings include:<br><br>On facility tour between 0745 AM and 10:30 AM on 07/14/2015, the review of the fire drill documentation for the past 12 months (July 2014 to June 2015) revealed the following:<br><br>1. The day shift fire drill was missed in the 4th | K 050 | K050: The maintenance director will make sure that a fire drill is performed on each shift every quarter. The maintenance director will adjust the timing of each fire drill conducted, making sure that the dates the fire drill is performed is spread out during each month. Additionally, the time the drill is performed during each shift will be spread out into 2 hour increments. The maintenance director and the executive director will discuss the schedule of each fire drill at the beginning of every month to ensure proper timing of the fire drill takes place. | 8/31/15 |

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| K 050 | Continued From page 5<br>Quarter of 2014<br>2. Did not sufficiently vary the times that the drills were conducted on the following shifts<br>a. evening - 1500, 1810, 1445 and 1909 hours<br>b. night - 0200, 0130, 0430 and 0230 hours<br><br>These deficient practices were confirmed by the Facility Maintenance Director (JM) at the time of discovery. | K 050 | | |
| K 076 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.5.2.2 (2). This deficient practice could all 6 out of 46 residents.<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 0745 AM and 10:30 AM | K 076 | K076: The Maintenance Director will post clear instructions in the oxygen room as to storage. A training session for all staff who handle oxygen tanks will take place to educate them on the new procedure. A signature page will be created for the training and will be kept in the Life Safety binder under the Oxygen Safety tab. The maintenance director will conduct audits | 8/31/15 |

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| K 076 | Continued From page 6<br>on 07/14/2015, observation revealed that the 1st floor oxygen storage room has empty and full "E" cylinders that were not segregated from each other.<br><br>This deficient practice was confirmed by the Facility Maintenance Director (JM) at the time of discovery. | K 076 | weekly during his morning rounds to make sure that empty/full tanks are properly separated. | |
| K 144 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.- 4.4(d). The deficient practice could affect all 46 residents.<br><br>Findings include:<br><br>On facility tour between 0745 AM and 10:30 AM on 07/14/2015, documentation review of the past 12 months (August 2014 to July 2015) generator logs, revealed that (7 out 12 months) there was no documentation for the minimum of 5 minute | K 144 | K144: The maintenance director will make sure that the generator runs at least an additional 5 minutes after the load has transferred back to the building during the monthly load testing. An additional line has been added to the monthly generator test report in Building Engines. This result asks for the minutes of cool down time to be entered on the report. If a time is entered that is less than 5 minutes, it will give the maintenance director an error and will ask him to correct it before he closes the task. | 8/31/15 |

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| K 144 | Continued From page 7<br>cool down time of the emergency generator.<br><br>This deficient practice was confirmed by the Facility Maintenance Director (JM) at the time of discovery.<br><br>*TEAM COMPOSITION*<br>Gary Schroeder, Life Safety Code Spc. | K 144 | | |

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically submitted
August 5, 2015

Ms. Margaret Holm, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, Minnesota 55972

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5270024

Dear Ms. Holm:

The above facility was surveyed on July 13, 2015 through July 17, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact 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 call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota | 2 000 | | |

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>On July 13, 14, 15, 16 & 17, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>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.<br><br>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.<br><br>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. | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 255 | MN Rule 4658.0070 Quality Assessment and Assurance Committee<br><br>A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to have the required members attend the Quality Assessment and Assurance Committee (QAA) at least quarterly. This deficient practice had the potential to affect all 45 residents who resided in the facility at the time of the survey.<br><br>Findings include:<br><br>Review of the facility's QAA meeting attendance record reviewed from 7-30-14 to 4-15-15 revealed the medical director attended the QAA meetings | 2 255 | Corrected. | 8/31/15 |

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| 2 255 | Continued From page 3<br>on 7-30-14, 10-15-14 and 4-15-15. The attendance record revealed no physician attended the QAA meeting held on 1-2-15.<br><br>On 07/17/2015 9:17 a.m. the director of nursing (DON) stated based on the documentation of meeting attendance for QAA meetings the medical director (MD) did not attend quarterly meetings in the last year. The DON verified the attendance records reflected MD had not attended the 1/2/15 quarterly review meeting.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator could educate the physician or his/her representative on the importance of participating in QA activities. Monitoring for compliance needs to be included too.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 255 | | |
| 2 570 | MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision<br><br>Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.<br><br>This MN Requirement is not met as evidenced | 2 570 | | 8/31/15 |

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| 2 570 | Continued From page 4<br>by:<br>Based on interview, and document review, the facility failed to update the plan of care for 1 of 2 residents (R45) reviewed for falls.<br><br>Findings include:<br><br>R45 was discharged to the hospital on 6/4/15, readmitted on 6/16/15 with primary diagnoses of cerebral artery occlusion with infarct (stroke), hemiplegia affecting non-dominant side due to cerebral vascular disease (left sided weakness due to stroke). Upon readmission R45's care plan was not updated to reflect his current functioning status leading to a fall on 6/29/15.<br><br>R45's 14 day Minimum Data Set (MDS) dated 6/29/15 revealed R45 required an extensive two plus person physical assist for bed mobility, transfers, walking in room, personal hygiene, dressing and toilet use. Locomotion on and off the unit required an extensive one person physical assist. Functional limitation revealed impairment on one side for both upper and lower extremity.<br><br>The care plan provided was not correct and did not match the MDS and did not reflect the current need for assistance. Care plan dated 2/5/15, revision 5/29/15, indicated R45 was a one person assist to ambulate to/from the bathroom, independent mobility in room, and R45 should ambulate with nursing two to three times daily without assistive device and a stand by assist of one. The care giver guide was found not to match the care plan.<br><br>07/16/2015 10:34 a.m. Registered Nurse (RN)-A and the Director of Nursing (DON) verified care plan copy given to surveyor is most current care | 2 570 | Corrected. | |

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| 2 570 | Continued From page 5<br>plan. Also verified the information on the care plan is conflicting, resident is not independent, and care plan has incorrect information.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 570 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the facility | 2 830 | Corrected. | 8/31/15 |

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| 2 830 | Continued From page 6<br>implemented physician orders to prevent edema for 1 of 1 resident (R33) reviewed who had a physician's order for antiembolism stockings.<br><br>Findings include:<br><br>R33's diagnoses were identified on the quarterly minimum data set (MDS) assessment to include: congestive heart failure (CHF), hypertension (HTN), diabetes mellitus (DM), cerebrovascular accident (CVA), dementia and atrial fibrillation.<br><br>Review of R33's Physician's Orders And Signature Form revealed an order dated 7/7/15, which directed "Needs Tubigrips or Compression stockings on AM (morning), off PM (evenings) secondary to edema."<br><br>On 7/16/15, at 9:09 a.m. R33 was observed being wheeled down the hallway towards the desk by a family member (F1) who was at the facility visiting. R33 was observed wearing sweat pants, and he had on ankle socks and house slippers. At the time of the observation both of R33's ankles were uncovered and were noted to be swollen as F1 took him into his room. At 9:13 a.m. F1 was observed in R33's room helping to put the TV (television) on. Although R33 had visible swelling of the ankles, R33 was not wearing observed to be wearing the compression.<br><br>On 7/16/15, at 12:26 p.m. R33 was observed in the dining room (DR) seated in his wheelchair at the table eating lunch. R33 was not wearing either Tubigrips or the compression stockings at that time but was still wearing the ankle socks. R33's ankles remained swollen.<br><br>On 7/17/15, at 8:19 a.m. and again at 9:03 a.m., R33 was observed seated on his wheelchair at | 2 830 | | |

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| 2 830 | Continued From page 7<br>the DR table. R33 was not wearing compression stockings nor Tubigrips but was wearing black ankle socks. Both ankles were uncovered and were observed to be swollen.<br><br>On 7/17/15, at 8:20 a.m. registered nurse (RN)-D was interviewed about whether or not the order dated 7/7/15, to apply Tubigrips or compression stockings for R33 was current. RN-D stated she would check after she was done with the breakfast medication pass.<br><br>On 7/17/15, at 8:57 a.m. the director of nursing (DON) stated she had talked to staff in the therapy department and learned that they had ordered the stockings. She further stated she had a staff person checking whether the stockings may have been sent to laundry. When asked if the stockings were sent to laundry daily the DON stated, "if they were soiled the staff would send them down because they aren't able to clean them in the sink."<br><br>On 7/17/15, at 9:03 a.m. nursing assistant (NA)-F stated, "For months he has not had TED (elastic) stockings. We can only tell the nurse the legs are swollen and we elevate them. I help him and have never seen them." NA-F verified R33's legs were swollen and stated R33 routinely wore ankle socks.<br><br>On 7/17/15, at 10:13 a.m. when asked who ordered the compression stockings RN-D stated the stockings would be ordered from the facility's own system and not from the pharmacy. RN-D indicated at the facility level there would be a person designated to make the orders the executive director or DON would be the ones to go in and accept the order placement. When asked whether the staff responsible for ordering | 2 830 | | |

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| 2 830 | Continued From page 8<br>the stockings was available, the ED stated the staff had called in sick for the day.<br><br>On 7/17/15, at 10:29 a.m. RN-D approached the surveyor and stated, "as we speak right now the Tubigrips are being applied and the compression stockings have been ordered." She acknowledged the order for the compression stockings had not been completed until now and verified R33 had swollen ankles.<br><br>On 7/17/15, at 11:29 a.m. the DON stated, "I would expect the order to be done and the stockings for this case to have been ordered and followed up to make sure they were delivered and applied. I expected the order to have been implemented." The DON acknowledged the compression stockings had not previously been ordered.<br><br>R33's care plan dated 3/20/14, indicated R33 had impaired cardiovascular status related to HTN and atrial fibrillation. The care plan directed staff to observe for, and report, signs of chest pain, edema, shortness of breath and to elevate the resident's lower extremities as indicated.<br><br>The facility's policy for Anti-embolism Stockings (Elastic Stockings), dated 2006, indicated the purpose of the stockings was to reduce edema, prevent embolus formation, to aid return circulation from lower extremities and to provide support to the lower extremities.<br><br>In addition, based on observation, interview and record review, the facility failed to implement appropriate interventions including supervision, eating assistance and/or appropriate textured food/fluids in order to prevent choking/aspiration of fluid and foods for 2 of 2 residents (R12, R51) | 2 830 | | |

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| 2 830 | Continued From page 9<br>who had been identified as at risk. The facility's failure to implement these interventions resulted in an immediate jeopardy situation for R12 and R51.<br>The immediate jeopardy began on 7/13/15 when it was first observed the facility failed to provide the necessary supervision, needed assistance, and food consistency for R12 and/or R51 during meal service observations. The facility administrator, a corporate executive administrator, and a clinical services specialist from the corporate office were notified of the immediate jeopardy at 5:32 p.m. on 7/14/15. The immediate jeopardy was removed on July 16, 2015 but noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.<br>Findings include:<br>R12 and R51's medical records were reviewed. Speech language pathologist (SLP) and physician progress notes indicated the residents were at risk for choking and aspiration. According to R51's medical record, R51 had been treated for aspiration pneumonia as recently as 5/12/15. At the time of admission, R12 had been identified as having a diagnosis of dysphagia (difficulty swallowing). Although these resident's had specific interventions in place for supervision, assistance, and modified diets, the facility failed to ensure these interventions were implemented consistently.<br>R12 was observed during the evening meal on 7/13/15, at 6:22 p.m. to sit at the dining room table independently drinking hot chocolate with no staff supervision. R12 was observed to begin to cough very loudly after a drink of the hot chocolate and the hot chocolate was observed to run out of his mouth. Nursing assistant (NA)-C, | 2 830 | | |

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| 2 830 | Continued From page 10<br>who had been passing out wipes to other residents in the dining room came over to R12, handed R12 a wipe and left the area. NA-C did not ask R12 if he was okay, or whether he was having difficulty swallowing the hot chocolate.<br>At 6:52 p.m. on 7/13/15, R12 again began to cough while eating. This time the cough was more violent and a pinkish/red colored liquid spewed from his mouth. There were no staff available in the immediate area, R12's face turned red as he continued to cough. Registered nurse (RN)-B came to the table about 2 minutes after the coughing had started and at 7:00 p.m., RN-B removed R12 (in his wheelchair) from the dining room while he continued to cough. R12 was taken out to the lobby. RN-B then re-entered the dining room and asked about what R12 had been served. RN-B stated the red apple sauce R12 had received was considered pureed fruit, and that the substance in the glass was a "thicker than pudding thick" fluid.<br>At 7:04 a.m., R12 was observed seated alone in the lobby at a small table against the wall. He had stopped coughing and his face color had returned to normal. R12 was noted to be facing towards the wall making him less easily visible by staff who might be in the area. RN-B had his food tray brought out and placed in front of him. Again R12 was left unsupervised with his meal. No staff were in the direct vicinity of R12, a licensed practical nurse (LPN)-A, was observed standing at a medication cart 15-20 feet away with her back to R12. At 7:11 p.m. R12 remained in the lobby area alone. A clinical psychologist (CP)-A was observed to approach R12 to remove his dinner tray at 7:13 p.m. At that time, the surveyor asked CP-A whether she'd had any formal training to assist residents with eating. CP-A stated she had not had any training for assisting residents to eat, but was removing the resident's | 2 830 | | |

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| 2 830 | Continued From page 11<br>tray because the surveyors were watching the resident.<br>During a breakfast meal observation on 7/14/15 at 9:03 a.m., R12 was observed to sit at the dining room table with his breakfast tray in front of him. There was no staff sitting with the resident or observed to be supervising the resident. R12 took a bite of cream of wheat, held it in his mouth for approximately 3 seconds and began to cough. Cereal was observed to drip out of his mouth and run down his chin. At 9:05 a.m. NA-C was observed to come over to R12 and whether he wanted a napkin. NA-C was heard to instruct R12 to "tuck and swallow." NA-C stayed at R12's table until 9:07 a.m. when she left R12's table and sat down at another table to feed a different resident. At 9:09 a.m. As R12 continued to eat his breakfast, he was observed to take several bites of food and hold it in his mouth for long periods of time before swallowing. R12 did not use the chin-tuck procedure while eating nor did staff monitor R12 while he was eating/chewing/swallowing or cue him to use the chin-tuck procedure. NA-C did not return to R12's table until 9:13 a.m.<br>During an interview on 7/14/15, at 9:24 a.m. Registered Dietician (RD)-A explained the baseline consistency for pureed food is applesauce, but verified the consistency of food and fluids for R12 should be pudding thick consistency. RD-A stated thickener should be added as needed to R12's food and fluid consistency was prepared as the physician had ordered. RD-A also stated, "people who have aspiration precautions, including R12, need direct supervision in the dining room."<br><br>During observation of lunch on 7/14/15 at 12:34 p.m., R12 sat at the table with a spoon in his mouth. No staff were present at the table or in | 2 830 | | |

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| 2 830 | Continued From page 12<br>direct view of R12 during this time. R12's meal tray included pureed carrots served at a honey thick consistency.<br>During an interview on 7/14/15 at 2:27 p.m., dietary assistant (DA)-A stated the dietary staff determined the consistency of R12's food by sticking a spoon in the food, and if the spoon stands straight up, it would be considered pudding thick. DA-A acknowledged she had served R12's carrots without having verified the consistency.<br>Following the facility's notification of the IJ, R12 was observed at 6:10 p.m. on 7/14/15 at the supper meal. R12 was seated at the dining table and was moaning loudly. RN-B was sitting between R12 and R51. R12 had attempted to take a heaping spoonful bite of cranberry juice. Although RN-B instructed R12 to take smaller bites, she did not instruct the resident to tuck his chin and swallow. Instead, R12 was observed to hold the cranberry juice in his mouth for approximately 7 seconds before swallowing. R12 took another bite that was smaller, chewed the bite, and was again observed to hold it in his mouth for several seconds. R12 took four more bites and each time held the food for several seconds in his mouth before swallowing. Throughout the observation, RN-B did not encourage R12 to use the chin-tuck technique. At 6:32 p.m. RN-B picked up R12's spoon and attempted to feed him. At 6:33 p.m. During the observation RN-B was also observed to assist R51 with eating. While RN-B was assisting R51, R12 resumed feeding himself. When RN-B returned to assist R12, she was observed to put food on the spoon and place bites in R12's mouth while there was still food in R12's mouth. R12 had food running out of his mouth, and was observed to hold food in his mouth at the same time. No instruction was provided for R12 to use chin-tuck | 2 830 | | |

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| 2 830 | Continued From page 13 | 2 830 | | |

then to swallow. At 6:39 p.m. R12 was observed to take a bite and to hold it in his mouth. R12 cried out "Ahh" and then began to cough. R12 then closed his mouth for a few seconds and when he opened his mouth again, a large amount of tan colored liquid drained out of his mouth onto his clothing protector. At 7:15 p.m. R12 was removed from the dining area and set in the lobby area.

During an interview with RN-B at 7:21 p.m. on 7/14/15, RN-B told the surveyor R12 had experienced a brief choking episode in the dining room. RN-B stated she and two nursing assistants had intervened. RN-B stated R12 had several bites of food in his mouth at the time. When the surveyor inquired, "How did he get that much food in his mouth?" RN-B stated, "He was eating right along and I thought he was swallowing but he didn't swallow. I was watching pretty close."

On 7/14/15, at 8:01 p.m. the director of nursing and administrator were informed of the concerns noted during the supper meal with R12.

During an observation of the breakfast meal on 7/15/15, at 8:20 a.m. R12 had been sitting at the dining room table with no staff member present at the table. Although R12 was served the correct consistency beverages, when R12 grabbed his spoon and attempted to remove a heaping bite of cranberry juice from the glass, RN-B walked by the table and only gave a verbal cue for R12 to take smaller bites. RN-B then walked away from the table without assisting R12 to take smaller bites of food, and without ensuring staff were present with R12 to supervise as he ate his meal. At 8:26 a.m. the surveyor brought to the attention of RD-A and RN-A that there was no one to supervise the resident as he attempted to eat the thickened drinks he had been served. At 8:27 a.m. RN-A was observed to sit down between

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| 2 830 | Continued From page 14<br>R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table ..." At 8:36 a.m. R12's meal was placed in front of him, and as he independently took a bite, he experienced a coughing incident. At that time, RN-A gave verbal cues to R12 to follow the chin tuck procedure. At 8:39 a.m. RN-A was observed to assist R51. At 8:41 a.m. NA-G sat down next to R51, however at 8:45 a.m. NA-G moved to the other side of the table to assist another resident, then walked away from the table to wash her hands. When NA-G left the table, RN-A also got up and moved to the other side of the table to assist the other resident leaving R12 without any assistance. NA-G returned to the table, however sat on the other side with her back to R12. After R12 had taken a couple of bites of food, copious amounts of saliva were observed to drain from his mouth. At that point the surveyor intervened and informed RD-A of the concern with R12 not being supervised while independently eating. RD-A got RN-B to sit with R12 at 8:58 a.m. until R12 had completed his meal.<br>R12 was admitted to the facility on 9/3/14 according to the facility admission record with diagnoses that included but were not limited to: dementia with behavioral disturbance, dysphagia (difficulty swallowing), esophageal reflux, central hearing loss, and anxiety disorder.<br>R12's quarterly Minimum Data Set (MDS) dated 5/26/15, indicated R12 had moderate cognitive impairment with a Brief Interview for Mental Status score of 10 which indicates confusion. The MDS indicated R12 had unclear speech, but responded adequately to simple direct communication. In addition, the MDS indicated R12 experienced coughing and/or choking during meals or when swallowing medication, and required staff supervision and assistance with | 2 830 | | |

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| 2 830 | Continued From page 15<br>eating and meal set up.<br>R12's quarterly nutrition assessment dated 6/12/15, indicated he had a swallowing disorder and required thickened liquids. The assessment included, "...Puree diet with pudding thick liquids, no white rice, no milk with meals ...r/t [related to] ongoing difficulties with swallowing..."<br>The record also indicated R12 had received speech therapy services from 2/18 through 5/6/15, for medical diagnoses of: cerebral vascular accident and treatment for dysphasia.<br>Therapy notes indicated:<br>4/6/15- "R12 choked four times during the session, had delayed swallowing of 2-3 seconds." In addition, the note indicated education was given to staff on holding spoon in mouth for 2 seconds to elicit swallow, adding moisture to meats if needed, and providing smaller bites.<br>4/7/15- "education was given to staff to present food from the resident's right side and to use the spoon for liquids."<br>4/8/15-"required maximum (max) amount of verbal cues to use chin tuck, displayed anxiety related to coughing during meal, and one episode of coughing related to staff feeding too fast." In addition the treatment note read, "Pt [patient] does not appear to be a good candidate for self-feeding, at this time continue POC [plan of care] with increase in staff education to decrease risk of aspiration."<br>4/9/15- The note indicated R12 held medications in his mouth and required maximum verbal and visual cues to swallow. The note also indicated the resident had 3 coughing episodes and then became anxious.<br>The speech therapist orders dated 4/10/15, were communicated on a form entitled Rehab Recommendations and included: "Pureed diet with honey thick liquids, Patient [R12] must have staff sitting by him at meals, cue for patient to | 2 830 | | |

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| 2 830 | Continued From page 16<br>tuck chin on swallow, clear mouth prior to next bite, use a spoon for drinks, and take small bites (help with bite size as needed)."<br>On 4/13/15 speech therapy had changed the order from honey thick liquids to pudding thick liquids.<br>4/15/15 - "...education was given to staff for cuing compensatory strategies (these would include taking small bites and sips, alternate bites and sips, avoid slurping and drinking through straws, sitting upright, chin tuck also known as head flexion, etc.) to assist R12 in swallowing safely, R12 had increased coughing when he fed himself, and education was given to staff 'on need for increased supervision during meals' in case of aspiration or airway blockage."<br>4/23/15 - "...maximum anterior oral spillage. Coming out right side. Max pocketing on right side. Verbally walked him through swallow [technique]."<br>R12's care plan was provided by the facility on 7/14/15. The care plan indicated R12 had difficulty swallowing related to a cardiovascular accident. The care plan interventions included for staff to use the physician ordered diet of pureed with pudding thick liquids, no white rice, and no milk with meals. The care plan further instructed staff to "encourage to follow SLP [speech language pathologist] recommendations, monitor coughing during meals, eating assistance of 1, allow rsdt [resident] to attempt to feed self with staff assist as needed." The care plan had not been revised to include the SLP's specific recommendations identified on 4/10/15.<br><br>R51 was observed at 9:13 a.m. 7/14/15, during the breakfast meal to be sitting at the dining table eating his meal independently. R51 was observed to have honey thickened fluids, scrambled eggs and oatmeal. There was not a staff person at the | 2 830 | | |

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| 2 830 | Continued From page 17<br><br>table to supervise R51. R51 was observed to take a bite of oatmeal and to chew. Almost immediately R51 began to cough. R51 was observed to take another bite of oatmeal and again coughed several times. Facility staff in the dining room were assisting other residents and did not check on R51 when he had these coughing episodes. At 9:19 a.m. a nursing assistant, (NA)-C, first came to R51's table but did not intervene for R51, but assisted one of his tablemate's with eating.<br><br>During an evening meal observation on 7/14/15, at 6:13 p.m. R51 was observed seated at the dining room table drinking what appeared to be honey thickened hot chocolate. Registered nurse (RN)-B sat between R51 and R12. At 6:23 p.m. R51's food, which was observed to be the appropriate consistency, was placed in front of him. From 6:23 p.m. to 6:28 p.m. R51 ate independently without any verbal cues from RN-B. R51 was observed to take large bites, and to take additional bites before swallowing what was in his mouth. At 6:28 p.m. RN-B turned to face R51 and instructed R51 to take smaller bites. At that time R51 moved the food to center of R51's plate and removed food that had fallen into R51's lap with a fork, and placed it back onto R51's plate. At 7:01 p.m. R51 started to cough and his face turned red. RN-B instructed R51 he needed to stop coughing before taking another bite. R51 waited until the coughing had stopped then took a drink, and again coughed several times but did not turn red. At 7:08 p.m. R51 took another drink and again began coughing, however staff did not give any verbal cues to use the chin tuck procedure prior to swallowing.<br><br>At 7:11 p.m. on 7/14/15, the director of nursing (DON) brought R51 out of the dining room in his | 2 830 | | |

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| 2 830 | Continued From page 18<br><br>wheelchair and placed him in front of the television and gave him a tissue. R51 coughed twice, as the DON walked away. At 7:13 p.m. R51 was observed to start coughing again, and after approximately 30 seconds his face turned red, clear liquid drained from his mouth, and R51 used the tissue to wipe his face. The coughing ceased after R51 wiped his face.<br><br>During an interview with RN-B at 7:21 p.m. on 7/14/15, following the evening meal, RN-B stated, "...towards the end of the meal he [R51] started sputtering, so I patted him on the back and he coughed and got it out of his throat, so he's alright, you can hear it cleared." When asked how she could tell it had cleared, RN-B stated, "You can tell that he cleared it because you couldn't hear it gurgling anymore."<br><br>During an observation of the breakfast meal on 7/15/15, at 8:20 a.m. R51 was again observed sitting at the dining room with no staff members present at the table. R51 was served the beverages of the correct consistency which he began to drink independently without staff supervision. RN-B was observed to walk by the table and provide verbal cues to R12, but did not offer any cues or assistance to R51.<br><br>At 8:26 a.m. on 7/15/15, RD-A was questioned about R51 having received his beverages prior to staff availability to assist him. RD-A stated she was not sure how that had happened. At 8:27 a.m. RN-A sat between R51 and R12 and stated, "I am sitting here because the drinks were prematurely delivered to the table." At 8:36 a.m. R51's meal was placed in front of him and at 8:39 a.m. NA-G sat next to the R51 who had helped himself to a heaping spoonful of French toast. When R51 had put the bite in his mouth, RN-A | 2 830 | | |

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| 2 830 | Continued From page 19<br>who was also sitting at the table looked at NA-G and said, "Tell him [R51] to take smaller bites." NA-G looked at R51 and told him to take smaller bites. At 8:45 a.m. NA-G moved away from R51 to assist his tablemate. R51 continued to eat independently without verbal cues. NA-G then walked away from the table to wash her hands. At the same time, RN-A got up and went to the other side of the table to assist R51's tablemate. When NA-G returned to the table, she sat at the opposite side from R51. At 8:58 a.m. RN-A continued to assist the tablemate (R12) with her back to R51. From 8:45 a.m. until 8:58 a.m. R51 was observed to eat independently, and was observed to take large amounts of food with each bite taken. At 8:58 R51 started coughing and his face turned red, RN-A suggested at that time that it would be good to "get a therapy referral for adequate chair positioning while eating."<br><br>R51's record was reviewed and the admission face sheet indicated R51 had been admitted to the facility on 11/5/13. In addition, according to the facility admission record, R51's diagnoses included: dysphagia, aspiration pneumonia, problems with swallowing and mastication (chewing), Parkinson's, dementia, and anxiety.<br><br>A Physician Visit note dated 5/12/15, indicated R51 had been seen that day because of a cough and low-grade temperature. The physician's exam revealed "crackles in right mid lung field and occasional expiratory wheeze." The physician documentation indicated R51 had been diagnosed with aspiration pneumonia, and had been prescribed Augmentin (an antibiotic) 875 milligrams (mg) twice a day for 7 days, and a nebulizer treatment for four days and as needed.<br><br>A nursing progress note dated 5/23/15 read, "...is | 2 830 | | |

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| 2 830 | Continued From page 20<br>able to fed [feed] self after set up, is at the feeder table for supervision. Eats slowly, is on nectar thick liquids."<br><br>R51's annual Minimum Data Set (MDS) dated 5/26/15, indicated R51 usually made self-understood however, had difficulty communicating some words or finishing thoughts, but was able if prompted and given time, to usually be understood by others. The MDS indicated R51 may miss some parts or intent of messages but comprehended most conversation. R51 was identified by the MDS to have a brief interview for mental status (BIMS) score of 11 which indicated mild cognitive impairment. The MDS further indicated R51 required limited physical assistance from one staff member for eating.<br><br>R51's nutritional assessment dated 6/19/15, identified a history of swallowing disorder. The assessment indicated the resident had a physician prescribed diet of mechanical soft with puree meets and vegetables with honey thick liquids, no added salt, no magic cups. The nutritional assessment summary note included, "...Resident has had some changes to diet d/t [due to] an occurrence [sic] of aspiration pneumonia in May [2015]...Resident is assisted at meal times now."<br><br>The record indicated R51 had received speech therapy from 3/3 through 4/17/15, to decrease signs and symptoms of penetration/aspiration, according to the Speech Therapy Progress and Updated Plan of Care form dated 3/3/15.<br><br>Speech therapy notes dated 3/19/15, included a written recommendation to change R51's diet from nectar thick liquids to honey thick liquids. | 2 830 | | |

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| 2 830 | Continued From page 21<br><br>On 3/24/15 speech therapy had made an additional recommendation to change R51's diet to mechanical soft with pureed vegetables and meats, and honey thick liquids. The recommendation included, "Supervision needed at meals, make sure eggs are pureed not scrambled."<br><br>Speech therapy progress notes dated 4/17/15, indicated R51 utilized, "safe swallowing strategies with 90% accuracy with minimal verbal cues."<br><br>R51's care plan provided by the facility on 7/14/15, identified a problem area of swallowing difficulties related to dysphagia and aspiration pneumonia. The care plan interventions directed staff to provide a diet of honey thick liquids, puree meats and vegetables, no magic cups, and to provide assistance at meals as the resident would allow. In addition the care plan indicated R51 was to sit at the 'assisted dining table'. The care plan had not been revised to include the specific speech therapy recommendations identified on 3/24/15.<br><br>During an interview with dietary assistant (DA)-A at 2:27 p.m. on 7/14/15, DA-A stated she was not aware R51 was not supposed to have scrambled eggs, but should have received eggs of a pureed consistency and did not.<br><br>During an interview with NA-K on 7/14/15 at 2:15 p.m. she stated, "Usually every day there are just two [identified R12 & R51] that cough, [R12] more often that [R51] ....R51 does good on his own eating, I don't need to sit by him when he eats."<br><br>During an interview with NA-C on 7/14/15 at 2:15 p.m. she stated, "R12 needs and should get | 2 830 | | |

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| 2 830 | Continued From page 22<br>direct supervision- he needs to be told to tuck his chin and swallow, he holds food in his mouth, what is happening right now is there isn't enough staff members to feed 10 people so we have to basically go back and forth. There are only two aides in the dining room during meals, sometimes management will help during the day but not during the evening. A nurse might help pass trays but they never are in the dining room during the whole meal service." NA-C stated both R12 and R51 cough at every meal at least 3 to 4 times. NA-C explained R51 needed supervision and cueing then said, " He's not as bad as [R12] " in reference to coughing.<br><br>During an interview on 7/14/15 at 2:19 p.m., NA-H was asked about R12 and R51's coughing during meals. She stated often R12 and R51 have coughing/choking episodes while eating. NA-H stated the coughing usually occurred because they both (R12 and R51) eat too fast.<br><br>During an interview on 7/14/15 at 7:15 p.m., NA-I stated she normally worked the evening shift and verified there are usually only two NA's in the dining room. NA-I stated a nurse might be able to help if they were done passing medications, but stated most of the time it is just the two aides.<br><br>During an interview on 7/14/15, at 7:21 p.m., NA-J stated she worked on the evening shift and that there are usually just two staff in the dining room to assist all of the residents that need assistance with eating. NA-J stated the nursing assistants have to move back and forth between the two tables. NA-J also stated R12 "likes to keep shoveling food in his mouth" and takes big bites and that is usually when food comes up. NA-J then explained prevention measures for R12 and R51 were to give verbal cues. | 2 830 | | |

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| 2 830 | Continued From page 23<br><br>A facility policy Eating Support was reviewed and did not identify guidelines to assist residents who required changes to textured diets or supervision of residents who were at risk for choking and/or aspiration. A policy pertaining to aspiration precautions was requested, however on 7/17/15, at 9:56 a.m. RD-A and DON stated the facility did not have a policy.<br><br>The immediate jeopardy that began on 7/13/15, was removed on 7/16/15, when it was determined the facility had completed assessments for R12 and R51 to rule determine their aspiration risks, had revised the residents' care plans to include current speech therapy recommendations, it was verified staff had been re-educated to understand the importance of supervision of the residents during meals, and had been re-educated to resident specific interventions for prevention of aspiration, and observation of a meal reflected appropriate implementation of interventions. However, noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm due to the facility's population including residents with swallowing difficulty.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing or designee, could review and revise policies and procedures related to implementation of physician orders, and implementation of interventions for residents who have potential for aspiration including assessment, monitoring and care, provision of staff education related to the care of residents. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. | 2 830 | | |

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| 2 830 | Continued From page 24<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 2 830 | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to establish an infection control program that included consistent monitoring of symptoms and type of infection, tracking of causal organisms and symptom resolution of infections. In addition, the facility failed to ensure a soiled isolation linen cart receptacle was not overflowing in R22's room; and failed to ensure appropriate clean technique was used when changing an indwelling catheter collection bag for R12. The facility's failure to establish an infection control program had the potential to affect all 45 residents who resided in the facility.<br><br>Findings include:<br><br>LACK of INFECTION CONTROL PROGRAM:<br><br>Facility Line Listing of Resident Infections flow sheet from 1/2015 to 6/2015 was reviewed. The flow sheet identified the following information which was to be collected by the infection control coordinator: Room, unit, resident name, admission date, type of infection, symptoms/date, | 21375 | Corrected. | 8/31/15 |

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| 21375 | Continued From page 25<br>cultures, treatment, other actions (if needed), and HAI (Healthcare Associated Infection) or CAI (Community Acquired Infection).<br><br>Document review Line Listing of Resident Infections flow sheet revealed the following:<br><br>1/2015, twelve residents in the facility had experienced possible infections. Eleven of the twelve residents had actual symptoms identified (i.e. increased urinary incontinence, cough, elevated temperature). Eleven of the twelve residents had type of infection identified. All twelve residents had antibiotic identified. None of the twelve residents had causal organisms identified. None of the twelve residents had symptom resolution identified.<br><br>2/2015, eight residents in the facility had experienced possible infections. Six of the eight residents had actual symptoms identified. All eight of the residents had type of infection identified. All eight residents had antibiotic identified. One of the eight residents had causal organisms identified. None of the eight residents had symptom resolution identified.<br><br>3/2015, Ten residents in the facility had experienced possible infections. Six of the ten residents had actual symptoms identified. Nine of the ten residents had type of infection identified. All ten residents had antibiotic identified. None of the ten residents had causal organisms identified. None of the ten residents had symptom resolution identified.<br><br>4/2015, Eleven residents in the facility had experienced possible infections. Seven of the eleven residents had actual symptoms identified. All eleven of the residents had type of infection | 21375 | | |

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| 21375 | Continued From page 26 | 21375 | | |

identified. All eleven residents had antibiotic identified. None of the eleven residents had causal organisms identified. None of the eleven residents had symptom resolution identified.

5/2015, Eleven residents in the facility had experienced possible infections. Nine of the eleven residents had actual symptoms identified. Ten of the eleven residents had type of infection identified. Nine of the eleven residents had antibiotic identified. None of the eleven residents had causal organisms identified. None of the eleven residents had symptom resolution identified.

6/2015, Partial listing of infections was provided. Three residents in the facility had experienced possible infections. Two of the three residents had actual symptoms identified. Two of the three residents had type of infection identified. All three residents had antibiotic identified. None of the three residents had causal organisms identified. None of the three residents had symptom resolution identified.

The facility's policy, Infection Control Program dated 4/6/15 included: "An infection control program designed to provide and maintain a safe, sanitary and comfortable work environment and to help prevent the development or transmission of disease or infection will be established for all facilities." Although requested, there was no further policy provided related to components of the infection control program.

During interview on 7/15/15, at 1:30 p.m. registered nurse-A (RN-A), stated she was responsible for the facility's infection control program. RN-A verified the facility Line Listing of Resident Infections was the facility's monitoring

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| 21375 | Continued From page 27<br>system for infections. RN-A verified monitoring from 1/2015 to 6/2015, lacked consistent monitoring of symptoms and type of infections. RN-A verified the infection control program lacked identification of causal organisms and lacked symptom resolution of infections.<br><br>LACK of PROPER Handling and Storage of Isolation Linens:<br><br>R22 was observed on 7/13/15, at 3:29 p.m. R22 had isolation containers in her room located up-against the wall. The lid of the linen container was ajar with soiled linens touching two pillows that had been sitting on top of chair adjacent to the container. NA-F had a covered clean linen cart outside of R22's room. NA-F came into the room. When asked about the overfull container, NA-F responded by explaining "that is an infection control issue," she further explained the linens should have been removed from the room. NA-F then stripped the pillow cases off the pillow without putting gloves on, touched the lid of the container to open it, touched the linens inside the container, and then walked outside of the room without washing her hands and touched the outside of the cover of the linen cart to pull the cover down over the clean linens. NA-F used the hand sanitizer located outside the resident's room and came back in the room and put gloves on. NA-F completed the removal of the linens using standard infection control practices.<br>During an interview on 7/16/15, at 3:37 p.m. DON stated R22 had VRE (Vancomycin Resistant Enterococcus) in an open wound that was now healed on her abdomen and was unsure if the VRE was in her ostomy. DON explained plan to call nurse practitioner (NP) to inquire if isolation precautions could be removed. DON stated NA should have washed her hands and donned | 21375 | | |

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| 21375 | Continued From page 28 | 21375 | | |

gloves prior to handling the pillow cases and touching the linen on the inside of the container, NA should have then taken off her gloves and washed her hands prior to leaving the room.

The facility provided guidelines for personal protective equipment for isolation circumstances, the guidelines directed staff to wash hands and use gloves.

A policy on storage and transportation of soiled isolation linen was requested and not received.

Urinary Catheter
During an observation of activities of daily living on 7/14/15, at 1:02 p.m. R12 was sitting on the toilet, nursing assistant (NA)-C explained urinary catheter collection bag had a hole in it and she was going to change it. NA-C removed the end cap from the new urinary collection bag tubing and draped the new tubing over the mechanical lift that had been in the bathroom, struggled to remove a connection piece on the actual Foley catheter. After the piece had been removed, NA-used an alcohol wipe to clean the end, NA-C then touched the floor with her right hand and with soiled gloves touched R12's clothing. NA-C did not remove her gloves or wash/sanitize her hands. NA-C proceeded to pick up the end of the tubing of the collection bag. NA-C then was going to connect the contaminated end of the collection bag. NA-C was stopped by surveyor before the new sterile tubing was connected, and a new collection bag was obtained.
R12's quarterly Minimum Data Set (MDS) dated 5/26/15 indicated moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 10, had a diagnoses of dementia, and had an indwelling Foley catheter.
During an interview on 7/16/15, at 3:37 p.m.

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| 21375 | Continued From page 29<br>director of nursing (DON) explained the NA should have taken off gloves and washed hands and donned new gloves after touching the floor and the resident's clothes and the collection bag tubing should not have been draped over the mechanical lift.<br>The facility provided policy Catheter (Indwelling) Insertion and Removal of (Female and Male) that was last reviewed 1/26/15, the policy did not include direction on changing urine collection bags.<br><br>SUGGESTED METHOD OF CORRECTION: The Director of nursing could in-service staff to follow and implement a sound infection control program and to monitor for compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21375 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must | 21426 | | 8/26/15 |

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| 21426 | Continued From page 30<br>be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 1 of 5 employees (EE) received two-step tuberculin skin test timely; failed to ensure 1 of 5 residents (R60) received two-step tuberculosis (TST) skin test; and failed to ensure a tuberculosis program that included evidence of staff tuberculosis training. This had the potential to affect all 45 residents in the facility, staff and visitors.<br>Findings include:<br>EMPLOYEE SKIN TEST:<br>EE had a hire date of 2/16/15, according to new hires employee roster. Document review of facility tuberculosis (TB) screening tool dated 2/16/15, revealed E-5 was screened for history, risk factors, and symptoms of tuberculosis on 2/16/15. The tool identified EE received first step tuberculin skin test on 2/16/15. The skin test was read on 2/19/15, with results 0 millimeters induration. The second step skin test was administered on 6/2/15 or more than three months from the first TST. The skin test was read on 6/4/15, with results 0 millimeters induration.<br>Document review of facility Tuberculosis Exposure Control Plan dated 1/6/15, revealed the following:<br>Page 11-Guidelines for skin testing for new admissions and new hires- "All new admissions, new associates, and volunteers as defined above will receive a 2-step Mantoux ...unless they | 21426 | Corrected. | |

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have a documented past positive."
"Step 2-to be administered 7-10 days after Step 1, if Step 1 is negative."
During interview on 7/15/15, at 1:30 p.m., registered nurse (RN)-A stated facility policy and her expectations were that the first step skin test was administered when hired, results read within 48-72 hours, and second step skin test administered seven days after the first step results were read. RN-A verified E-5 did not receive the second step skin test according to facility policy. RN-A stated she did not know why the the skin test had been administered 3 plus months after the first test.
RESIDENT SKIN TEST:
R60 was admitted to the facility on 12/3/14, according to facility Line Listing of Resident Infections for 1/2015. Document review of facility baseline TB screening tool for residents dated 12/4/14, revealed R60 was screened for history, risk factors, and symptoms of tuberculosis on 12/4/14. Document review of facility baseline TB screening tool for residents dated 12/4/14, revealed no documented evidence date results of the skin test had been read, no documented evidence of induration of skin test, and no documented evidence of administering the second step skin test.
Document review of facility immunization record for R60, revealed tuberculin skin test was given on 12/4/14. There was no documented evidence date results of the skin test had been read, no documented evidence of induration of skin test, and no documented evidence of administering the second step skin test.
Document review of facility Tuberculosis Exposure Control Plan dated 1/6/15, revealed the following:
Page 11-Guidelines for skin testing for new admissions and new hires- "All new admissions,

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new associates, and volunteers as defined above will receive a 2-step Mantoux ...unless they have a documented past positive."
"Step 1-to be administered on admission/or on hire,"
"Step 2-to be administered 7-10 days after Step 1, if Step 1 is negative."

During interview on 7/15/15, at 1:30 p.m., RN-A verified R60 lacked results of the first step skin test and lacked evidence of received second step skin test. RN-A stated facility policy and her expectations were the first step skin test results were read within 48-72 hours, and second step skin test administered seven days after the first step results were read. RN-A verified R60 did not receive the second step skin test according to facility policy.
STAFF TRAINING:
Document review of facility Tuberculosis Exposure Control Plan dated 1/6/15, revealed the following:
Page 3-Oversight Function included "education and training."
Page 4-In-Service of Associates "Job positions requiring the performance of such tasks are appropriately identified and explained to each associate before initial patient/resident assignment."
Page 7-Administrative Measures included "educating and training applicable persons."
Although requested, no evidence of staff tuberculosis training was provided.
SUGGESTED METHOD OF CORRECTION:
The director of nursing could review tuberculosis policies and procedures to ensure compliance.
The director of nursing could educate nursing staff to their policies and procedures for employee and resident tuberculosis skin tests.
The director of nursing could provide all staff

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| 21426 | Continued From page 33<br>ongoing tuberculosis training. The director of nursing could monitor staff compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21426 | | |
| 21530 | MN Rule 4658.1310 A.B.C Drug Regimen Review<br><br>A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.<br>B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.<br>C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending | 21530 | | 8/31/15 |

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| 21530 | Continued From page 34<br>physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure the consultant pharmacist identified lack of irregularities for non-pharmacological interventions utilized prior to administration of as needed (PRN) medications for behavioral outbursts for 3 of 5 residents (R8, R41 & R22) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R8's most recent physician order sheets signed and dated 7/7/15, revealed that R8 had orders for the following psychoactive medications: Ativan (anxiety medication) 0.5 milligrams (mg), apply to pulse areas topically every 4 hours as needed for anxiety, and to apply Ativan gel to pulse areas.<br><br>R8's Medication Administration Record revealed:<br>On 7/3/15, Ativan 0.5 mg was administered topically for anxiety. No documentation of behavior.<br>On 5/14/15; 5/23/25 (no documentation of behavior) Ativan 0.5 mg was administered topically for anxiety, and on 5/29/15, no behavior documentation on that day, Ativan 0.5 mg was administered topically for anxiety.<br>On 4/15/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for | 21530 | Corrected. | |

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| 21530 | Continued From page 35<br>anxiety.<br>On 1/10/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety.<br><br>In addition, there was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.<br><br>R8's nurses' notes were reviewed from 8/3/14-7/12/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R8's ativan.<br><br>A review of the nursing assistant care sheets for R8 for the past year also revealed there had been no direction provided for the nursing assistants to attempt non-pharmalogical interventions for R8's behaviors.<br><br>R41's most recent physician order sheets signed and dated 7-9-17 (error-was to be 7/9/15) revealed that R41 had orders for the following psychotropic medications: Ativan Solution (antianxiety medication), Apply to pulse regions topically as needed for anxiousness and agitation, Supplied in 1 mg/ml individual syringe dose. Apply 0.5 ml topically to pulse points as needed. Cover with a Tegaderm if the resident is rubbing the medication off.<br>Review of R41's Medication Administration Record (MAR) revealed as follows:<br>a. On 4/3/15 - Ativan Solution 0.5 milliliters (ml) was administered for anxiety and<br>b. On 5/15/15; 5/24/15; Ativan Solution 0.5 ml was administered for anxiety. There was no documentation on the MAR that | 21530 | | |

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non-pharmacological interventions were attempted by staff prior to administering the Ativan Solution to R41.

R41's nurses' notes were reviewed from 4/3/15 to 5/24/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R41's antipsychotic medication.

On 7/16/15 at 1:13 p.m. the DON stated non-pharmacological interventions should be attempted prior to administration of the PRN medications. The DON stated the interventions should be documented in the progress notes or behavior charting. The DON confirmed there was no documentation of non- pharmacological interventions on 4/3/15, 5/15/15, or 5/24/15 for R41.

On 7/16/2015 5:58 p.m. the consultant pharmacist (CP)-A stated documentation of attempted non-pharmacological interventions should be completed in residents' medical record for the use of PRN medications.

On 7/17/15 at 7:05 a.m. CP-A stated he had spoken to his supervisor and monitoring for non-pharmacological interventions prior to using PRN medications was not part of the monthly pharmacy review.
The Clinical Pharmacist Services Agreement commencing on August 26, 2014 read, "...1. Scope of Services...1.2 perform a comprehensive medication regimen review ("MRR") of each Facility Patient at least once a month and report in writing any irregularities, deviations, or unusual occurrences to Facility's Executive Director, Medical director, Director of Nursing and/or, where appropriate, to the Patient's attending

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| 21530 | Continued From page 37<br>physician; 1.3 review the drug regimen of each Facility Patient at least once a month and report in writing any irregularities, deviations or unusual occurrences..."<br><br>R22 was admitted to the facility on 12/29/14 according to the facility admission record with diagnoses that included but was not limited to rheumatoid arthritis, abscess of anal and rectal regions, malignant neoplasm intestinal tract, perforation of intestine, osteoporosis, muscle weakness, pathological fracture of a vertebrae, obesity, and chronic pain.<br>R22's quarterly Minimum Data Set (MDS) dated 6/30/15 indicated no cognitive impairment with a Brief Interview for Mental Score (BIMS) score of 15 and required extensive assist from staff to complete activities of daily living. The MDS further indicated the resident received scheduled pain medication and utilized as needed pain medication.<br>R22's care plan provided by the facility on 7/14/15 informed staff of the need for pain management related to: osteoporosis and rheumatoid arthritis. The care plan directed staff to administer pain mediation as ordered, identify items/activities that could serve to distract pain, evaluate the need for routinely scheduled medications rather than PRN pain medication administration, evaluate the need to provide medications prior to treatment or therapy, implement the patient's preferred non-pharmacological pain relief strategies (rest, repositioning, movement to a quiet environment)<br>R22's physician orders provided by the facility on 7/15/15 included the following PRN (as needed) pain medication: Tylenol 650 milligrams (mg) by mouth every six hours as needed for pain and restlessness, and Dilaudid 2 mg by mouth every 2 hours as needed for pain between 2:00 p.m. and 2:00 a.m. | 21530 | | |

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| 21530 | Continued From page 38<br>R22's medication administration records (MAR) were reviewed from June 1,2015 through July 14, 2015.<br>The June MAR indicated R22 was administered PRN Tylenol three times total and that it had been used in combination with the PRN Dilaudid; records indicated the Tylenol was administered prior to the PRN Dilaudid. However, the MAR indicated the Tylenol had not been administered after 6/7/15. The MAR indicated PRN Dilaudid had been administered a total of 56 times in June; 53 doses were administered without prior dosing of Tylenol or in combination with Tylenol. It was not evident in the medical record Tylenol was offered for R22 prior to administration of PRN Dilaudid. It was also not evident in the medical record non-pharmacological interventions were attempted prior to administration of Dilaudid for any of the doses administered.<br>July's MAR indicated no use of the PRN Tylenol and PRN Dilaudid was administered 13 times. It was not evident in the medical record non-pharmacological interventions were attempted prior to the administration of PRN Dilaudid for any of the doses administered.<br>R22's nursing progress notes were also reviewed for June and July, the majority of the progress notes simply indicated the PRN pain medication that was administered, the intensity of the pain using a 0-10 pain scale, if the pain medication was "effective" or "ineffective." The progress notes lacked a pain assessment/evaluation that would include location and characteristics or description of the pain.<br>During an interview on 7/16/15 at 11:18 a.m., the director of nursing (DON) verified the absence of documentation of non-pharmacological intervention prior to the administration of PRN pain medication. The DON stated her expectation was that staff would fully document a pain | 21530 | | |

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| 21530 | Continued From page 39<br>evaluation which would include the use of non-pharmacological interventions and the outcome.<br>The facility's policy Medication Monitoring and Medication Management, last revised November 2011, did not reflect current standards for use of non-pharmacological interventions prior to use of PRN medications.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The Director of nursing could in-service all staff responsible for medication monitoring including consultant pharmacist on the need to use non-pharmacological interventions before use of or along side medication use. Monitoring for compliance needs to be done also.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21530 | | |
| 21535 | MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General<br><br>Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:<br>A. in excessive dose, including duplicate drug therapy;<br>B. for excessive duration;<br>C. without adequate indications for its use; or<br>D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.<br>In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for | 21535 | | 8/31/15 |

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| 21535 | Continued From page 40<br>Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to implement and document non-pharmalogical interventions prior to using as needed (PRN) medications for behavioral outbursts or pain, for 3 of 5 residents (R8, R41 and R22) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R8's most recent physician order sheets signed and dated 7/7/15, revealed that R8 had orders for the following psychoactive medications: Ativan (anxiety medication) 0.5 milligrams (mg), apply to pulse areas topically every 4 hours as needed for anxiety, and to apply Ativan gel to pulse areas.<br><br>R8's Medication Administration Record revealed:<br>On 7/3/15, Ativan 0.5 mg was administered topically for anxiety. No documentation of behavior.<br>On 5/14/15; 5/23/25 (no documentation of behavior) Ativan 0.5 mg was administered topically for anxiety, and on 5/29/15, no behavior documentation on that day, Ativan 0.5 mg was administered topically for anxiety.<br>On 4/15/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety. | 21535 | Corrected. | |

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| 21535 | Continued From page 41<br><br>On 1/10/15, (no behavior documentation on that day), Ativan 0.5 mg was administered topically for anxiety.<br><br>In addition, there was no documentation on the medication administration record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan to R8 for 5 of 6 doses administered.<br><br>R8's nurses' notes were reviewed from 8/3/14-7/12/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R8's ativan.<br><br>A review of the nursing assistant care sheets for R8 for the past year also revealed there had been no direction provided for the nursing assistants to attempt non-pharmalogical interventions for R8's behaviors.<br><br>R41's most recent physician order sheets signed and dated 7-9-17 (error in date) revealed that R41 had orders for the following psychoactive medications: Ativan Solution (antianxiety medication), Apply to pulse regions topically as needed for anxiousness and agitation, Supplied in 1 mg/ml individual syringe dose. Apply 0.5 ml topically to pulse points as needed. Cover with a Tegaderm if the resident is rubbing the medication off.<br><br>R41's Medication Administration Records revealed:<br>a. On 4/3/15 - Ativan Solution 0.5 milliliters (ml) was administered for anxiety and<br>b. On 5/15/15; 5/24/15; Ativan Solution 0.5 ml was administered for anxiety. There was no documentation on the medication administration | 21535 | | |

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| 21535 | Continued From page 42 | 21535 | | |

record (MAR) that non-pharmacological interventions were attempted by staff prior to administering the Ativan Solution for R41.

R41's nurses' notes were reviewed from 4/3/15 to 5/24/15 and revealed no documentation to indicate that non-pharmacological interventions were attempted prior to the administration of R41's psychoactive medication.

On 7/16/15 at 1:13 p.m. the DON stated non-pharmacological interventions should be attempted prior to administration of the PRN medications. The DON stated the interventions should be documented in the progress notes or behavior charting. The DON confirmed there was no documentation of non-pharmacological interventions on 4/3/15, 5/15/15, or 5/24/15 (dates when R41 received PRN ativan).

R22 was admitted to the facility on 12/29/14 according to the facility admission record with diagnoses that included but was not limited to rheumatoid arthritis, abscess of anal and rectal regions, malignant neoplasm intestinal tract, perforation of intestine, osteoporosis, muscle weakness, pathological fracture of a vertebrae, obesity, and chronic pain.
R22's quarterly Minimum Data Set (MDS) dated 6/30/15 indicated no cognitive impairment with a Brief Interview for Mental Score (BIMS) score of 15 and required extensive assist from staff to complete activities of daily living. The MDS further indicated the resident received scheduled pain medication and utilized as needed pain medication.
R22's care plan provided by the facility on 7/14/15 informed staff of the need for pain management related to: osteoporosis and rheumatoid arthritis. The care plan directed staff to administer pain

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| 21535 | Continued From page 43<br>mediation as ordered, identify items/activities that could serve to distract pain, evaluate the need for routinely scheduled medications rather than PRN pain medication administration, evaluate the need to provide medications prior to treatment or therapy, implement the patient's preferred non-pharmacological pain relief strategies (rest, repositioning, movement to a quiet environment)<br>R22's physician orders provided by the facility on 7/15/15 included the following PRN (as needed) pain medication: Tylenol 650 milligrams (mg) by mouth every six hours as needed for pain and restlessness, and Dilaudid 2 mg by mouth every 2 hours as needed for pain between 2:00 p.m. and 2:00 a.m.<br>R22's medication administration records (MAR) were reviewed from June 1,2015 through July 14, 2015.<br>The June MAR indicated R22 was administered PRN Tylenol three times total and that it had been used in combination with the PRN Dilaudid; records indicated the Tylenol was administered prior to the PRN Dilaudid. However, the MAR indicated the Tylenol had not been administered after 6/7/15. The MAR indicated PRN Dilaudid had been administered a total of 56 times in June; 53 doses were administered without prior dosing of Tylenol or in combination with Tylenol. It was not evident in the medical record Tylenol was offered for R22 prior to administration of PRN Dilaudid. It was also not evident in the medical record non-pharmacological interventions were attempted prior to administration of Dilaudid for any of the doses administered.<br>July's MAR indicated no use of the PRN Tylenol and PRN Dilaudid was administered 13 times. It was not evident in the medical record non-pharmacological interventions were attempted prior to the administration of PRN Dilaudid for any of the doses administered. | 21535 | | |

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| 21535 | Continued From page 44<br><br>R22's nursing progress notes were also reviewed for June and July, the majority of the progress notes simply indicated the PRN pain medication that was administered, the intensity of the pain using a 0-10 pain scale, if the pain medication was "effective" or "ineffective." The progress notes lacked a pain assessment/evaluation that would include location and characteristics or description of the pain.<br>During an interview on 7/16/15 at 11:18 a.m., the director of nursing (DON) verified the absence of documentation of non-pharmacological intervention prior to the administration of PRN pain medication. The DON stated her expectation was that staff would fully document a pain evaluation which would include the use of non-pharmacological interventions and the outcome.<br>The facility's policy Medication Monitoring and Medication Management, last revised November 2011, did not reflect current standards for use of non-pharmacological interventions prior to use of PRN medications.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The Director of nursing could provide training for staff responsible for medication administration related to the need to include non-pharmacological interventions in lieu of medications when possible. The facility could include the importance of non-pharmacological interventions in meeting the needs of residents in their facility medication policies and could develop a system to monitor implementation.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21535 | | |

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| 21565 | Continued From page 45 | 21565 | | |
| 21565 | MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin<br><br>Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to conduct an assessment to determine whether a resident was capable to self administer medications for 1 of 1 resident (R8) reviewed for self administration of medication.<br><br>Findings Include:<br><br>R8's quarterly Minimum Data Set (MDS) assessment dated 6/9/15, identified the resident as having moderately impaired cognitive skills for daily decision making. In addition, the MDS indicated the resident's diagnoses included anxiety state. Current physician's orders identified on the July 2015 Medication Administration Record, included use of Miralax Powder (medication for constipation), give 1 scoop by mouth in the evening for constipation.<br><br>On 7/13/15 at 7:04 p.m. a cart with supper trays was observed to be taken from the kitchen by the activity director (AD)-A and registered nurse (RN)-B. Licensed practical nurse (LPN)-A stopped the supper tray cart and asked which tray was for R8. LPN-A removed the chocolate milk from R8's supper tray and poured powdered medication from a medication cup into the | 21565 | Corrected. | 8/31/15 |

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chocolate milk. LPN-A verified she'd poured Miralax into R8's chocolate milk. LPN-A returned the chocolate milk to the supper tray and put the tray back into the cart. LPN-A then went back to the medication cart to proceed with passing medications for other residents. AD-A and RN-B continued towards the middle hall. After delivering R8 her supper tray at approximately 7:08 p.m., RN-B was heard to ask the administrator, "can you watch her? She has Miralax in that cup." RN-B returned at 7:13 p.m. and prompted R8 to drink her chocolate milk.

At 7:14 p.m. RN-B was questioned by the surveyor about whether or not R8 had been assessed to self administer the Miralax medication. R8 stepped away for a moment and immediately returned stating, "she has an order to self administer." When asked whether there had been an assessment of R8's ability to self administer the medication, RN-B stated, "I don't know, but I'll just take it away so you don't have to stand here." RN-B was then observed to take the chocolate milk from R8.

On 7/13/15 at 7:30 p.m. LPN-A was asked if it was routine practice to place Mirilax in R8's chocolate milk and send the tray to her room with whomever is delivering trays. "With her it is. She will not drink it if I bring it in. We have to do it that way. She just gets agitated when people watch her." When LPN-A was asked whether R8 had been assessed to self administer medications she stated, "I don't know, we just have to get creative to get her to take her meds."

On 7/13/15 at 7:38 p.m. RN-A verified R8 did not have an assessment completed to identify R8's ability to self administer medications. RN-A also verified that it would not be normal practice to

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| 21565 | Continued From page 47<br>place medication into a resident's chocolate milk and send with the meal tray.<br><br>A Self Administration of Medications form completed for R8 on 2/10/14 indicated: Resident/patient request to self administer medications: 'No. No assessment completed.' The Interdisciplinary team (IDT) follow up date was 5/19/14, and was identified as a quarterly review. The note indicated 'No changes'.<br><br>The facility's policy: Medication Adminstation-General Guidelines, Section 7.2 dated 5/12 included: "B. Administration 5. The person who prepares the dose for administration is the person who administers the dose. 13. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications."<br><br>SUGGESTED METHOD OF CORRECTION: The facility could review their medication, self administration, policy and procedure, provide education to staff, they could ensure assessments are completed prior to allowing residents to self administer medications, the facility could also develop and audit tool and system to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days. | 21565 | | |
| 21665 | MN Rule 4658.1400 Physical Environment<br><br>A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use | 21665 | | 8/31/15 |

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| 21665 | Continued From page 48<br>personal belongings to the extent possible.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure lift sheets were maintained in proper repair and were kept clean. This had the potential to affect 11 of 11 residents residing in the facility who utilized the shared lift sheets.<br><br>Findings included:<br><br>On 7/7/15, at 9:00 a.m. a transfer lift was observed parked in the hallway on the 100 Wing. Hanging on top of the lift was a blue lift sheet which was observed to be soiled with multiple brown, white and green stains. In addition the mesh cloth attached underneath the the lift sheet, was observed to be torn off and the ripped mesh was hanging loose.<br><br>On 7/16/15, at 9:30 a.m. another transfer lift machine was observed stationed in mid-hallway of the 300 Wing. The blue lift sheet was observed to be soiled with brown and white spots on the lift sheet.<br><br>On 7/16/15, at 12:30 p.m. to 12:47 p.m. during the environmental tour with the maintenance manager (MM) he verified both the lift sheets for the Sit to Stand lifts were not clean. When asked what the brown, white and green spots/marks were MM was not able to indicated and stated when they were dirty laundry department would clean them. When asked how often the lift sheets were cleaned MM stated he was not sure. MM further stated the facility currently had two Sit to Stand transfer lifts as one had gone down | 21665 | Corrected. | |

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| 21665 | Continued From page 49<br>recently.<br><br>On 7/16/15, at 12:53 p.m. the director of nursing (DON) verified the lift sheet in the Sit to Stand transfers lift in the 100 Wing was soiled and was with ill repair. When asked what her expectation was of staff DON stated she expected staff to send the lift sheets to laundry for cleaning when they noticed it was not clean. In addition the DON stated she would have expected the staff to report to her the lift sheet was in ill repair but indicated she had been out of the facility and was not sure if the lift sheet had been ordered. DON further stated the lift sheets were shared amongst residents in the facility.<br><br>On 7/16/15, at 1:55 p.m. the MM approached the surveyor and stated he had found out the lift sheets were cleaned as needed and would be sent down to laundry when dirty.<br><br>On 7/16/15, at 5:11 p.m. registered nurse (RN)-A approached the surveyor to provide names of residents that shared the Sit to Stand transfer lift and the manual lift. When asked whether there was a cleaning schedule for when the shared lift sheets were cleaned, RN-A stated there was no schedule and stated the lift sheets were supposed to be cleaned when dirty. RN-A acknowledged the lift sheets were shared and needed to be kept clean as they went from room to room.<br><br>On 7/16/15, at 5:30 p.m. a Sit to Stand transfer lift was observed stationed by the fire door in the 100 Wing outside room 104 and the lift sheet which was hanging on top of the machine was still observed to be soiled even though the concern had been brought to the facility's attention. | 21665 | | |

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| 21665 | Continued From page 50<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 21665 | | |