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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 531Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245228**
2.STATE VENDOR OR MEDICAID NO.
(L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/02/2009**

6. DATE OF SURVEY **03/14/2017** (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)
09/30

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Lois Boerboom, HFE NE II — 05/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 05/09/2017 (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
08/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245228

May 9, 2017

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Dear Ms. Derynck:

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 March 8, 2017 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing andCertification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 9, 2017

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Number S5228027

Dear Ms. Derynck:

On February 13, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 18, 2017. (42 CFR 488.422)

Also, on February 13, 2017 we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

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

Futhermore, as we notified you in our letter of February 13, 2017, 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 April 27, 2017.

This was based on the deficiencies cited by this Department for an extended survey completed on January 27, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On March 14, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 8, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 27, 2017, as of March 8, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 8, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)

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

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

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245228 Y1	A. Building B. Wing Y2	3/14/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0282	Correction
Reg. # 483.12(a)(3)(4)(c)(1)-(4)	Completed	Reg. # 483.12(b)(1)-(3), 483.95(c)(1)-(3)	Completed	Reg. # 483.21(b)(3)(ii)	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	03/08/2017
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0318	Correction
Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(c)(2)(3)	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	03/08/2017
ID Prefix F0497	Correction	ID Prefix F0520	Correction	ID Prefix	Correction
Reg. # 483.35(d)(7)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i)(ii) (h)(i)	Completed	Reg. #	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	05/09/2017	34083	3/14/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/27/2017

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245228 Y1	A. Building 02 - NEW BUILDING AND RENOVATED EXISTING BLD B. Wing Y2	3/6/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0351	01/31/2017	LSC	K0711	02/15/2017	LSC	K0781	02/15/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0918	02/15/2017	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	5/9/2017	35482	3/6/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/24/2017

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 9, 2017

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: Reinspection Results - Project Number S5228027

Dear Ms. Derynck:

On January 27, 2017 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 March 14, 2017, with orders received by you on February 20, 2017. 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
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00343 Y1	A. Building B. Wing Y2	3/14/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20255	Correction	ID Prefix 20565	Correction	ID Prefix 20830	Correction
Reg. # MN Rule 4658.0070	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	03/08/2017
ID Prefix 20850	Correction	ID Prefix 20895	Correction	ID Prefix 21995	Correction
Reg. # MN Rule 4658.0520 Subp. 2 D	Completed	Reg. # MN Rule 4658.0525 Subp. 2.B	Completed	Reg. # MN St. Statute 626.557 Subd. 4a	Completed
LSC	03/08/2017	LSC	03/08/2017	LSC	03/08/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/27/2017	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 531Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245228**

2.STATE VENDOR OR MEDICAID NO.
(L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/02/2009**

6. DATE OF SURVEY **01/27/2017** (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)
09/30

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

12.Total Facility Beds **76** (L18)

13.Total Certified Beds **76** (L17)

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Holly Kranz, HFE NE II — 02/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/17/2017 (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
08/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted
February 13, 2017

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Number S5228027

Dear Ms. Derynck:

On January 27, 2017, 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 January 26, 2017, 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
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
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 February 18, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F309. (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, Avera Morningside Heights Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective January 27, 2017. 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 April 27, 2017 (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 July 27, 2017 (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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A survey was conducted by the Minnesota Department of Health on January 23, 24, 25, 26, & 27, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F309 related to the facility's failed response to ensure timely emergent care after an esophageal food bolus obstruction which resulted in the high potential for harm or death. The IJ began June 21, 2016, was identified by survey staff on 1/25/17 at 4:15 p.m., and was removed on 1/26/17 at 9:09 a.m. An extended survey was conducted by the Minnesota Department of Health on January 25, 26, & 27, 2017.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect,	F 225		3/8/17

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

Electronically Signed | 02/20/2017

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F 225	Continued From page 1 exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established	F 225		

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F 225	Continued From page 2 procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to immediately report and investigate potential neglect of care for 1 of 8 incidents (R66) reviewed for abuse reporting requirements. R66 experienced an esophageal food bolus obstruction on 6/17/16 and was ordered to be transferred to the emergency department by her primary physician, however nursing staff failed to implement the physician's orders. Findings include: Refer to F309 - Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. This resulted in immediate jeopardy for R66, who experienced actual harm due to delayed treatment for an esophageal obstruction	F 225	Preparation, submission and implementation of this plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. Thank you. VA report filed/submitted to MDH/OHFC on 1/30/17. Report received from OHFC on 2/14/17 that no further action taken by office at this time. On-going compliance: Nurse managers and DON will review all QM's daily, each working day, to assess for potential VA	

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F 225	Continued From page 3 resulting in pain, esophageal irritation and risk of aspiration pneumonia/airway compromise as well as actual harm for R116, who had a history of cardiac disease and experienced delayed treatment for severe chest pain. A facility email, dated 6/21/16 indicated the director of nursing (DON) was informed R66 had not been taken to the emergency room immediately as per physician's orders after an esophageal food bolus obstruction by R66's primary physician (MD-B). The DON then conferred with the administrator (A), who subsequently contacted the medical director for a chart review. A report was not immediately made to the state agency (SA) regarding the incident, and an internal investigation into the incident including all relevant staff members was not completed at the time. When interviewed on 1/27/17, at 8:16 a.m. the director of nursing (DON) stated R66's incident was not reported to the SA since there was not an incident of abuse nor neglect, rather the medical director had completed his own internal review. The DON stated "looking back on it, it might have been reportable, certainly if there would have been a bad outcome for the patient it would have been." The facility's Vulnerable Adult Abuse Prevention Plan, last revised 1/2017 indicated: Avera Marshall will not condone abuse of any patient, resident, client and/or participant, by anyone including staff, physicians, volunteers, visitors, or family members. Definition of abuse: the deprivation by an individual, including a care taker, or goods or services that are necessary to attain or maintain physical, mental, and	F 225	situations. Nursing staff to submit change in condition form to the DON on all residents who require physician intervention or show a change in condition. Don will review for appropriateness of care. These forms will be reviewed with the medical director weekly. Summaries of the findings will be reported monthly to the LTC Quality Committee meeting. Education will be provided to all staff on reporting obligations and procedures during March staff meetings. All staff will receive annual education on VA policies and procedures via CBL (computer based learning), and upon hire. Nurses will be provided education on completing a change in condition form/transfer form for all residents who require physician intervention or transfer. Tracking tool will be used to monitor for immediate reporting of VA's. All VA reports will be reviewed at monthly LTC Quality Committee meetings.	

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F 225	Continued From page 4 psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. The policy defined neglect as: Failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All health care employees are mandated reporters. A report is required if there is reason to believe that abuse or neglect has occurred. Immediately means as soon as possible, within minutes of knowledge of the incident. Response to incidents is initiated by conducting a internal investigation of the incident and reporting alleged incidents of neglect to the appropriate state agency. Taking all necessary corrective action. Analyzing the occurrence and determining if any changes are needed in the plan to prevent further occurrences. Keeping an internal log of reports. The policy directed all staff to report any and all incidents of alleged abuse and/or neglect. If a report should be filed with OHFC, the report will be made immediately, upon knowledge of the incident. Review of a decision pathway attached to the Vulnerable Adult Abuse Prevention Plan, identifies that once the administrative personnel are aware of a incident a report is made to the office of health facility complaints (OHFC) immediately. Once a resident care assessment (investigation) is completed, a final report is then submitted to OHFC within 5 days of the incident.	F 225		

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F 226	Continued From page 5	F 226		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to implement the Vulnerable Adult	F 226	VA report filed on 1/30/17. Report received from OHFC on 2/14/17 that no	3/8/17

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F 226	Continued From page 6 Abuse Prevention Plan to ensure immediate reporting of allegations of potential neglect to the State Agency (SA) for 1 of 8 incidents reviewed (R66) who experienced a decline in health status without being transferred to the emergency room immediately as ordered by her primary physician. Findings include: Refer to F309 - Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. This resulted in immediate jeopardy for R66, who experienced actual harm due to delayed treatment for an esophageal obstruction resulting in pain, esophageal irritation and risk of aspiration pneumonia/airway compromise as well as actual harm for R116, who had a history of cardiac disease and experienced delayed treatment for severe chest pain. The facility's Vulnerable Adult Abuse Prevention Plan, last revised 1/2017 indicated: Avera Marshall will not condone abuse of any patient, resident, client and/or participant, by anyone including staff, physicians, volunteers, visitors, or family members. Definition of abuse: the deprivation by an individual, including a care taker, or goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the	F 226	further action will be taken by office at this time. On-going compliance: Nurse managers and DON will review all QM's daily to assess for potential VA situations. Nursing staff will submit change in condition form to the DON on all residents who require physician intervention or show a change in condition. DON will review for appropriateness of care. These forms will be reviewed with the medical director weekly for appropriateness of care. Summaries of the findings will be reported monthly to the LTC Quality Committee meetings. Education will be provided to all staff on reporting obligations and procedures during March staff meetings All staff will receive annual education on VA policies and procedures via B+CBL, and upon hire. Nurses will be provide education on completing a change in condition form/transfer form for all residents who require physician intervention or transfer. Tracking tool will be created to monitor for immediate reporting of VA's. All VA's will be reviewed at monthly LTC Quality Meetings	

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F 226	Continued From page 7 use of technology. The policy defined neglect as: Failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All health care employees are mandated reporters. A report is required if there is reason to believe that abuse or neglect has occurred. Immediately means as soon as possible, within minutes of knowledge of the incident. Response to incidents is initiated by conducting a internal investigation of the incident and reporting alleged incidents of neglect to the appropriate state agency. Taking all necessary corrective action. Analyzing the occurrence and determining if any changes are needed in the plan to prevent further occurrences. Keeping an internal log of reports. The policy directed all staff to report any and all incidents of alleged abuse and/or neglect. If a report should be filed with OHFC, the report will be made immediately, upon knowledge of the incident. Review of a decision pathway attached to the Vulnerable Adult Abuse Prevention Plan, identifies that once the administrative personnel are aware of a incident a report is made to the office of health facility complaints (OHFC) immediately. Once a resident care assessment (investigation) is completed, a final report is then submitted to OHFC within 5 days of the incident. A facility email, dated 6/21/16 indicated the director of nursing (DON) was informed R66 had not been taken to the emergency room immediately as per physician's orders after an esophageal food bolus obstruction by R66's primary physician (MD-B). The DON then	F 226		

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F 226	Continued From page 8 conferred with the administrator (A), who subsequently contacted the medical director for a chart review. A report was not immediately made to the state agency (SA) regarding the incident, and an internal investigation into the incident including all relevant staff members was not completed at the time. When interviewed on 1/27/17, at 8:16 a.m. the director of nursing (DON) stated R66's incident was not reported to the SA since there was not an incident of abuse nor neglect, rather the medical director had completed his own internal review. The DON stated "looking back on it, it might have been reportable, certainly if there would have been a bad outcome for the patient it would have been."	F 226		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the plan of care for grooming services related to shaving for 1 of 3 residents (R54) reviewed for activities of daily living (ADL's), and failed to ensure a splint was applied to prevent further development of contractures for 1 of 1 resident (R45) reviewed for range of motion.	F 282	Therapy recommendations for ROM and splint placement will be posted (privacy protected) in residents room as a communication tool for staff to assure correct procedure and placement of splint and ROM activities. Resident grooming will be completed to remove unwanted facial hair, personal shaver will be	3/8/17

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F 282	Continued From page 9 Findings include: On 1/23/17, at 4:22 p.m. R54 was observed seated in recliner in her room. R54 had long unshaven facial near her chin along the jawline on the right side of her face. The hairs were approximated 1/4-1/2 inch in length. The facial hair continued to be present all days of the survey from 1/23/17 through 1/27/17. The care plan revised 1/7/17, for R54 identified a personal care activity of daily living (ADL) goal as noted: It is very important to my mental health that I look well dressed/groomed daily. Interventions included requiring assist of staff for all grooming needs. R54's annual Minimum Data Set (MDS) assessment dated 1/4/17, included a Brief Interview for Mental Status (BIMS) score of 6/15, indicating severe cognitive impairment, and required extensive assistance with personal hygiene. R54's diagnoses included hemiplegia (paralysis on one side of the body) following CVA (cerebrovascular accident/stroke) affecting the right dominant side. When interviewed on 1/26/17, at 2:37 p.m. nursing assistant (NA)-A stated residents need to have their own shavers if wanting to be shaved. NA-A confirmed R54 did not have her own shaver nor had asked to be shaved. When interviewed on 1/27/17, at 11:02 a.m. NA-A confirmed R54 had long unshaven facial hair mainly on the right side of face, explaining she was aware of the facial hair and questioned R54 approximately 6 months ago whether she desired	F 282	obtained for resident. On-going compliance: resident care planning process will be reviewed and revised as appropriate for each resident. Resident care sheets will be updated to reflect resident us of splints or braces for all residents. Staff education will be provided at March staff meetings on care planning and dignity. Expectation will be that all residents have grooming and facial hair removed as residents condition indicates. Nurse managers will monitor compliance with care plan by monitoring 10 percent of residents on a monthly basis for use of splints/braces and appropriate grooming/cleanliness. Tracking tool will be used for monitoring. Results of monitoring activities will be recorded on facility quality scorecard and reported at monthly LTC Quality Committee meeting	

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to be shaved; however, R54 declined. NA-A also stated R54 did not a personal shaver and if she desired to have one, the family would need to purchase a shaver. NA-A verified that R54 preferred to look nice (requested to wear a necklace daily) and had a hair appointment every Monday after her bath. Upon entering R54's room with the surveyor present, NA-A asked R54 whether she preferred to have her facial hair removed if a shaver was purchased for her use. R54 responded, "Yes" and nodded her head up and down. After leaving the room, NA-A approached administrative assistant (AA)-A at the front desk to inform AA-A of R54's need for a personal shaver. When questioned who was responsible for acquiring the shaver, AA-A stated R54's family would have to purchase unless approval was given to use funds from R54's personal funds account for staff to purchase a shaver.

When interviewed on 1/27/17, at 11:27 a.m. clinical manager (CM)-B verified residents were required to have their own razor. CM-B stated in the past the facility had community shavers available for resident use but they were not always thoroughly cleaned. Due to the risk of infection if not thoroughly cleaned, residents were required to purchase their own personal shavers. CM-B also confirmed there were no extra shavers available for resident use at this time. CM-B verified the facility was responsible to meet R54's grooming needs per the plan of care.

When interviewed on 1/27/17, at 11:50 a.m. AA-A confirmed the beauty shop did have a shaver available for residents who did not have their own personal shaver to meet their grooming needs. R45's care plan, last revised 1/16/17, identified

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F 282	Continued From page 11 R45 wore a hand splint in right hand/arm 6-8 hours per day and a carrot splint at all times in left hand. The care plan further directed staff to see therapy directions in R45's room for splints/braces. R45's current undated splint order stated: right hand forearm splint/brace on for 6-8 hours per day....on 6:00 a.m. off at 2:00 p.m. Review of R45's quarterly Minimum Data Set (MDS) assessment dated 1/11/17, identified R45 as comatose with a diagnosis of traumatic brain injury (TBI). It further identified R45 as having impairment on both sides of upper extremities with functional limitation in range of motion. On 1/24/17, at 9:32 a.m. R45 was observed lying in bed with a carrot splint in place to left hand. No splint was on right hand at this time. Nursing assistant (NA)-B stated R45 only wore a carrot splint to his left hand, and did not wear or utilize any other splint devices for right hand. On 1/24/17, at 2:06 p.m., licensed practical nurse (LPN)-A was observed to apply a splint to R45's right hand. LPN-A stated R45 was suppose to have splint on and NA-B must have forgot to put it on R45 earlier, indicating it was to be applied with morning cares by the NA. During interview on 1/24/17, at 2:07 p.m. NA-E and NA-D both stated they were only aware of R45 wearing a carrot splint to left hand and not aware of any other devices or splints for right hand. On 1/26/17, at 10:12 a.m. ROM exercises were completed to both upper extremities by NA-C and NA-D with carrot splint placed to left hand; however, no splint was applied to R45's right	F 282		

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F 282	Continued From page 12 hand following the ROM. On 1/27/17, at 8:07 a.m. R45 was laying in bed dressed and groomed, no splint to right hand. At 9:21 a.m. NA-G verified R45 had carrot splint in place on left hand, and stated no other splint is worn by resident. At 9:27 a.m. NA-F also indicated R45 did not wear a right hand splint. During interview on 1/27/17, at 10:22 a.m. LPN-C verified R45 did not have a right hand splint applied as ordered and that splint instructions had not been posted in the room as directed on the plan of care. During interview on 1/27/17, at 10:23 a.m. the director of nursing (DON) confirmed she expected staff to follow the plan of care and verified R45 was to have a right hand splint on 6-8 hours per day as ordered.	F 282		
F 309 SS=J	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309		2/17/17

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F 309	Continued From page 13 the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. This resulted in immediate jeopardy for R66, who experienced actual harm due to delayed treatment for an esophageal obstruction resulting in discomfort, esophageal irritation and risk of aspiration pneumonia/airway compromise as well as actual harm for R116, who had a history of cardiac disease and experienced delayed treatment for severe chest pain. The immediate jeopardy began on 6/21/16, when the administrator was made aware of nursing staff's failure to transfer R66 to the emergency room at the direction of her primary physician, and was identified on 1/25/17. The administrator, director of nursing and long-term care director of quality were notified of the immediate jeopardy on 1/25/17, at 4:15 p.m. The immediate jeopardy was removed on 1/26/17, but noncompliance remained at the lower scope and severity level of G - isolated, which indicated actual harm that is not immediate jeopardy.	F 309	Policy and process map reviewed and updated to reflect current reporting regulations, definitions added to reflect what constitutes as an emergency situation requiring emergency room transfer (chest pain, cardiac symptoms, stroke symptoms, seizure activity, choking, and intractable pain). Physician Services and Resident Care policies reviewed and updated to reflect use of eLTC services. Process maps developed for non-emergent resident transfer situations and for physician/medical services provided in LTC. On-going compliance: 1:1 education to 100% of licensed nurses on situations of emergencies requiring immediate transfer and definitions of emergent situations requiring immediate transfer completed on 1/26/17. eLTC use and emergency definitions and process maps added to all new licensed nurse orientation. Nursing staff to submit change in condition forms to DON on 100% of all residents who require physician intervention or show a change in condition. DON will review forms for appropriateness/timeliness of care. Forms will be reviewed with medical	

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F 309	Continued From page 14 Findings include: R66's diagnoses identified on the physician orders signed 4/25/16, included: esophageal stricture, chronic obstructive pulmonary disease (COPD), asthma, dysphonia, dysphagia, gastroesophageal reflux disease (GERD) and dementia. R66's annual Minimum Data Set (MDS) assessment dated 8/23/16, identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS also indicated that R66 fed herself independently, had a swallowing disorder, a mechanically altered diet, and exhibited coughing or choking during meals or when swallowing medications. Review of a Care Area Assessment (CAA) dated 8/23/16, related to nutritional status, revealed R66 had swallowing problems and required a special diet or altered consistency. The CAA indicated R66 had experienced a choking episode requiring transfer to the Emergency room (ER). R66's care plan Updated: 8/18/15 included, "Self-Feeding: I am able to feed myself with staff setup." R66's care plan last revised on 1/8/17 and authored by registered nurse (RN)-F, identified "Diet: NDD3 with ground meat and thin liquids" Also included "My diet was changed to a dysphagia diet and my meat is ground because I had an instance of choking on a piece of chicken in the dining room. I have had problems with my esophagus in the past and have had it dilated before. It is safer tor me to have my meats ground up to not eat real chunky foods. I prefer to have small portions at meals & like to be offered	F 309	director weekly. Summaries of the findings will be reported monthly to the LTC Quality Committee meetings and reviewed at monthly licensed staff meetings.	

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snacks between meals ... Staff and nurses should watch for symptoms increasing related to my esophageal stricture such as coughing at mealtimes, more difficulty swallowing, so they can notify my Dr. and SLP [speech language pathologist] per Dr. order."

According to the record, speech language pathologist (SLP) services had been initiated on 12/30/16. On 1/24/17 the speech language pathologist (SLP) documented, "the resident is currently receiving speech therapy to strengthen voice and to evaluate a report from staff of increased coughing during eating."

During observation on 1/24/17 at 2:25 p.m., R66 was having a speech therapy session in her room. At that time, the SLP acknowledged R66 was working on voice strengthening. R66 was observed to be actively participating in the session.

During an interview with R66 on 1/26/17 at 12:10 p.m., having had walked out to the dining room with assistance, and stated it felt good to walk. In addition, R66 stated she was having no pain or discomfort at this time.

On 1/26/17 at 12:37 p.m., R66 was observed to have eaten her entire meal and when finishing the liquids R66 coughed twice.

A preoperative history and physical document, authored by MD (medical doctor)-B, dated 6/17/16 at 3:30 p.m. included the following information in regards to R66 choking on a piece of chicken and needing urgent medical treatment:

"HISTORY OF PRESENT ILLNESS: The patient

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has a previously known peptic acid stricture. Her last EGD, (Esophagogastroduodenoscopy, a procedure during which a small flexible endoscope is introduced through the mouth and advanced through the pharynx, esophagus, stomach, and/or duodenum), and dilatation was in April of last year (2015) and she has been doing exceedingly well since then. Today at lunch she took her first bite of her chicken sandwich and it apparently got stuck. The staff at the nursing home tried to get her to take sips of water, tried to cough, they even tried to get her to regurgitate the pieces of chicken up but that all did not work. They contacted me and I asked them to send the patient to the emergency room. For reasons that I still do not quite understand the staff did not bring her to the emergency room as I requested, as they stated "she needed to have a face-to-face visit first". I explained to the nurse that this is a medical emergency and that she should go to the emergency room directly and I did call [MD-C] and he was waiting for her in the ER to come. I was just notified shortly ago that they were still waiting for me to come to the nursing home. I then brought the patient over here ...with her son, [FM-1] present. The patient still has some chicken stuck in her throat. She is able to speak but she has not been able to swallow and has been regurgitating into any emesis bag off and on her spit and secretions. She does not have any pain except she states that "my chest feels full"... PAST SURGICAL HISTORY: She has had multiple EGDs, as well as dilatations...IMPRESSION: 1. Acute impaction of chicken following lunch today...PLAN: Urgent EGD to remove the foreign body. More than likely we will probably have to stretch or dilate her at a later date in the near future, probably within 1-2 weeks. This is an emergent EGD."

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F 309	Continued From page 17 The Esophagogastroduodenoscopy Procedure Report dated 6/17/16, included: "Indications: Dysphagia in response to solids, causing acute impaction...The gastroscope was passed with great difficulty through the mouth under direct visualization and advanced to the second portion of the duodenum. The scope was withdrawn and the mucosa was carefully examined...Findings: Esophagus: A large quantity of food was found in the middle third of the the esophagus, 30 centimeters (cm) from the entry site. The food was removed with a basket, with success. Stenosis was found to be causing a moderate obstruction in the middle third of the esophagus, 34 cm from the entry site. The obstruction was traversed (laying across). Moderately erythematous (redness of skin secondary to injury, infection) mucosa was found in the middle third of the esophagus..." Journal of Gastroenterology & Hepatology, The independent Peer-Reviewed Journal, Gastroenterol Hpatol (NY) 2007 Feb; 3(2): 85-86 includes the following definition: The typical presentation of a patient experiencing a food bolus impaction includes a food bolus impactions are acute events that, for the most part, are immediately recognized by the patient. Most food bolus impactions resolve without intervention, either by moving forward to the stomach or by the patient regurgitating the ingested contents. When symptoms of obstruction persist and/or are accompanied by substantial chest discomfort, patients will seek medical attention. Patients primarily experience a sensation of squeezing in the chest, which can be frightening as it is difficult to discriminate from	F 309		

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heart attack pain. However, food bolus impaction is additionally associated with sialorrhea or excessive salivation, which accompanies esophageal obstruction. Patients are also unable to eat or drink anything further when experiencing an impaction.

It is important to differentiate impaction from choking. Patients with food bolus impaction do not have any interruption of breathing. They can talk and they can cough, whereas a person who is truly choking is unable to do any of these things.

Some of the classic presentations of food bolus impaction are " the steakhouse syndrome " or the " backyard barbeque syndrome. " Not surprisingly, impactions occur more often when patients are eating meat and generally when they do not chew their food sufficiently. Contributing conditions could be poor dentation, illfitting dentures, the use of alcohol, or a predisposition to eat too quickly. The most commonly impacted foods are beef, chicken, pork, and al dente-cooked vegetables.

Review of the nursing progress notes identified as List Resdent (sic) Notes from 6/17/16 to 6/26/16 revealed the following documentation:

On 6/17/16 as having occurred at 1230 (12:30 p.m.) but recorded at 2000 (8:00 p.m.) 6/18/16, authored by registered nurse (RN)-A: "Staff reported to RN that resident had been coughing at lunch time and had a emesis of liquids served at mealtime and bits of food. Upon entering room, this nurse found resident sitting in wheelchair holding an emesis bag with son by her side. Resident complained of pain and pointed to upper

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abdomen area. No complaints of difficulty breathing. Observed intermittent coughing and spitting up of clear secretions. Encouraged resident to cough and take sips of water to try to dislodge food stuck in esophagus without success. Contacted eLTC (a technology based system for medical provider evaluation) to ask for further advice. Spoke with MD [a first name was then documented with a ? behind the name] who recommended having resident swallow some crackers or other sot foods and wait and see if obstruction cleared spontaneously, otherwise send her to the ED (emergency department) if it hadn't cleared by supper time. At this point, son was wanting her to be seen by someone else since these attempts had been unsuccessful. On call physician, Dr [full name, MD-B] was updated about the situation and wanted her to be sent to the ED for further evaluation but unable to see resident prior to an ED transfer. MD-B came to see resident and take her to ED at around 1520 (3:20 p.m.)." An addendum had also been documented by RN-A at 12:44 p.m. on 6/19/16 related to 6/17/16 incident, "Resident returned to nursing home around 1800 (6:00 p.m.) with family. New orders for diet change and to contact on call doctor if temperature increases to 101. Will monitor for signs of aspiration per orders. Vitals normal range. Resident comfortable and wanted to try a little mashed potatoes and soft vegetables for supper."

A note recorded by RN-C on 6/18/16 at 7:44 a.m., for an occurrence from 6/17/16 at 2200 (10:00 p.m.) included: "Resident says she has slight sore throat from having a piece of food caught in her throat and brought to ER to have it removed. She swallowed water well gave medication whole without trouble. T (temperature) 98.6, P (pulse)

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F 309	Continued From page 20 64, BP (blood pressure) 110/63, O2 sat (oxygen saturation) 94%, R (respirations) 20." 6/19/16 at 6:00 p.m., RN-A documented, "Resident continues to be free of pain and able to eat regular meals throughout the rest of the weekend with no difficulty. Vitals normal range throughout weekend after return from procedure. Lungs clear all fields. Will continue to monitor for signs of aspiration." 6/28/16 at 10:07 a.m., licensed practical nurse (LPN)-D documented, "Resident brought back from same day surgery post endoscopy with dilatation by her son [FM-1], resident is eating breakfast at this time, Temp 97.2, pulse 71, B/P 174/77. Denies any pain. Done eating states, "I feel like I have to burp." MD-B was interviewed on 1/24/17 at 4:08 p.m., regarding the incident R66 had when food became lodged in her esophagus 6/17/16 during the noon meal. MD-B said he was the medical doctor on call that day and was working at the local clinic located 8 blocks from the nursing home. MD-B said that RN-A had called him form the nursing home to report that R66 had choked on chicken, and had not been able to swallow some of the meat. MD-B stated he had given RN-A an order to send R66 to the ER. MD-B stated he had proceeded to call the on call doctor for the ER, a surgical circulating nurse, and anesthesia, to be ready when R66 came to the ER and that the nursing home had been advised to bring her immediately to the ER. MD-B went on to explain that R66 needed an emergency surgical procedure in regards to the chicken stuck in her esophagus. MD-B stated when he had finished with the clinic patient he was seeing, he	F 309		

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had immediately gone to the hospital's ER to check on the status of R66. MD-B said when he got to the ER, R66 was not in the ER or surgical area. On further investigation, he said he'd been told that R66 was still over at the nursing home. MD-B stated he then had a phone call from RN-B to speak with him. MD-B was informed by RN-A that R66 had to be first seen for a "face to face" visit by a doctor or telemedicine to assess her and determine if she should be seen in the emergency room. MD-B stated when he heard that, he immediately went to the nursing home (connected to the ER) and found R66 holding an emesis bag while in her room. MD-B stated he had spoken to RN-B and informed her R66 "should have been seen in the ER" and that he "did not order telemedicine!" MD-B said RN-B had asked, "What makes this a medical emergency?" MD-B said he had responded to RN-B's question by saying, "When you are drooling, spitting and not able to swallow, you are putting your airway at risk." MD-B then said that this type of medical emergency also includes patient comfort, protection for the airway, and that there was an increased risk for aspiration pneumonia. MD-B said he was in "Awe" that the nursing home had not immediately sent R66 to the ER in accordance with his orders. In regards to requiring a "face to face" and or telemedicine before a resident can be seen in the ER, MD-B said that must be a policy of the nursing home . MD-B said that after talking to the nursing home staff about not having had taken R66 to the ER immediately he had proceeded to take R66 to the ER himself. He stated FM-1 who had been visiting R66 at the time, had gone along to the ER. MD-B stated at the ER they had initiated immediate assessment and preparation for a surgical intervention to remove the lodged

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F 309	Continued From page 22 chicken meat in the resident's esophagus. MD-B further stated he had spoken to the director of nursing (DON) by phone following the incident involving R66 not being taken immediately to the ER as he had ordered and wanted this to be looked into by the facility. MD-B said he had been informed by the DON, that the facility was trying to prevent unnecessary visits to the ER. MD-B explained further his understanding from the DON was that the nursing home is using an on call medical system called e-LTC. He stated he'd told the DON, "They [nursing home staff] did not call the telemedicine this time, they called me!" MD-B said the DON had asked him "What makes this a medical emergency?" and that he had explained what constitutes a medical emergency, and why R66 had a medical emergency based on this incident. He said he'd told the DON, "This was an emergent EGD." MD-B further stated that during the phone call with the DON, he had been assured that the facility would look into his concern regarding the resident's care. However, MD-B said there had been no follow-up received concerning R66's emergency medical concern. MD-B again said without an immediate intervention for R66 to remove the food obstruction, the risk for aspiration increased, and R66 experienced unnecessary discomfort by having to wait to have the food removed. MD-B stated, "Common sense did not prevail in this situation, these impactions are very uncomfortable and there was definitely a delay in treatment." MD-B then stated it was his impression that the directive to have a "face to face" or eLTC did not come from the hospital or the ER, but rather that it was the nursing home's policy.	F 309		

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Family member (FM)-1 was interviewed on 1/25/17 at 4:36 p.m., in regards to R66's medical emergency on 6/17/16. FM-1 stated that he had come to visit his mother after lunch on 6/17/16, and that she "was miserable" and not feeling well. FM-1 said, "I remember the day, it was not handled very good." FM-1 stated a nursing assistant (NA) was in the room with R66 when he'd arrived. He said the NA had been encouraging his mother to cough, but she had food stuck in her throat and kept spitting up. FM-1 again stated, "She was pretty miserable." He then stated staff called the doctor at the Avera e-Care-Long Term Care (eLTC a telemedicine service) and had his mother drink water, eat something soft, and tried to do the Heimlich maneuver. FM-1 said, it seemed like all that she'd eaten came back up, but her throat was still blocked. FM-1 said he was told by RN-A that the doctor had said they were to wait until supper (several hours away) to see if the stuck piece of chicken would resolve by itself. FM-1 said on hearing that, he'd requested RN-A to call another doctor. RN-A called medical doctor (MD)-B, who said that he would immediately notify the emergency room (ER) and surgery so they would be prepared for his mother who might require surgical intervention to remove the food. FM-1 confirmed staff had been told to bring R66 over to the ER immediately by MD-B. FM-1 then stated, "we were on our way over to the emergency room when [RN-A] got a phone call that the transfer was off and then said we had to return to the nursing home." FM-1 said when they returned back to his mother's room "RN-A assured me that he would work on it and get it worked out, but it was another 2 hours of watching my mother be miserable until MD-B came in personally and took her to the ER around 5 p.m. FM-1 said when

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F 309	Continued From page 24 MD-B came in and saw R66 was still in her room "he was not very happy, I think he was more upset then I was." FM-1 added that it had been upsetting to watch his mother suffer stating, "it was mom and I. The NA came into the room two times and the nurse once." FM-1 said when no one seemed to do anything to relieve her discomfort then added, "[MD-B] ended up doing the whole thing himself, and he got the situation handled." FM-1 also stated once she got to the ER, MD-B had his mother go into surgery to have the piece of chicken removed, and that the entire time they'd waited to be seen in the ER, his mom had been miserable and had filled three [emesis] bags with secretions she'd spit up. FM-1 stated he did not blame RN-A because "it was something else in between, he was caught." FM-1 further stated his mother had previously had problems, especially when eating too fast and that her esophagus had been stretched more then once before. FM-1 explained that there was a very narrow passage way, and a softer diet is required. When FM-1 was asked if anyone followed up with him after this episode, FM-1 stated the 'foundation head' person had called and apologized for the way the situation had been handled. FM-1 said he had been told by the foundation head that the matter would be looked into and had been assured it would not happen again to his mother or any other resident. When FM-1 was asked if he was knowledgeable about the eLTC service, he stated. "I was not aware of the telemedicine Dr. no one has ever talked to me about that." FM-1 expressed relief that MD-B had intervened and stated, "he [MD-B] was concerned about a potential rupture, or that coughing all of that time would cause more damage."	F 309		

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F 309	Continued From page 25 Registered nurse (RN)-A was interviewed on 1/25/17 at 8:17 a.m., in regards to the events that happened on 6/17/16 with R66's choking episode. RN-A was asked about the "face to face" eLTC protocol the nursing home utilizes. RN-A said, "On weekends, basically the policy is if the doctor from Avera is here and if they are not available to see the patient [face to face/in person], the nurse can use eLTC system. If the nurse cannot make contact with the doctor [on call], use of the eLTC is always an option for the nurse." RN-A confirmed eLTC had been contacted regarding R66's choking episode on 6/17/16. He verified eLTC doctor had ordered small sips of water, or soft food to try to dislodge the partial obstruction of meat. RN-A stated, when the interventions did not work, he called MD-B, who gave the order to send R66 to the ER. RN-A stated that MD-B was not able to see the resident to do a "face to face" before the transfer, and confirmed it was the facility's policy that if a provider was from the affiliated community medical center (ACMC) versus Avera the MD was supposed to come over to the nursing home to see the resident first and complete a "face to face." RN-A also stated in an emergency situation, such as a stroke or a heart attack, the nurse can use nursing judgement to send the resident directly over to the emergency room. After reviewing the documentation of R66's choking event on 6/17/16, RN-A stated that R66 was coughing up some things, but her airway obstruction did not appear to be "emergent." RN-A further stated R66 "was not turning blue or I would have thought her airway was blocked." RN-A confirmed that MD-B had come over to the facility, and added that the MDs were all aware of the policy regarding the use of eLTC system. RN-A further stated the ACMC providers signed a contract/policy and confirmed that if a family	F 309		

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stated they wanted their family member to go to the ER, the nurse must contact the resident's MD to do a "face to face" first. RN-A referred to a care path that is on every care center unit in a binder, to be used to determine if eLTC should be used or not. When asked if the incident on 6/17/16 had been reviewed with him by administration, RN-A stated the incident had been reviewed with him by clinical manager (CM)-A. RN-A continued to say, "I remember that CM-A reminded us to review the current protocols in place, including the care paths." RN-A also said that before the facility had started to use eLTC services, trainers had come in from Sioux Falls, South Dakota to talk with the nursing staff about the use of eLTC.

Medical Director (MD)-A was interviewed on 1/25/17 at 11:55 a.m., in regards to the events that occurred on 6/17/16 with R66's choking episode. MD-A stated that the goal of the eLTC program was for the patient to see a provider timely. The eLTC providers are available via telephone, or camera, and will order labs, tests, medications, intravenous access (IV), x-rays, etc. that can be completed at the nursing home. MD-A explained that the facility has a grant, and are trying to utilize the service to support immediate access to the MD, and to prevent unnecessary use of the emergency room (ER) to contain costs. MD-A continued to say that the eLTC service is not appropriate when there is an acute change, such as if the resident had an emergency due to impaired airway, stroke, breathing, and/or cardiac arrest. MD-A explained that there are protocols or pathways the staff are to use and they are located on all the units in the care center for the nurse to follow. MD-A added that "a lot of the situations are non-emergent." MD-A was asked if he participated in the training of care center staff on

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F 309	Continued From page 27 the eLTC protocols and he said he had not. MD-A said that utilization reports are emailed to him as they occur for his patients. MD-A was asked whether he was aware of R66's medical emergency on 6/17/16, and he said he had reviewed the situation. MD-A stated the event was reviewed previously between administration and himself, and that in his opinion, the situation was handled correctly. MD-A confirmed that the patient was miserable, however stated the resident did not have signs or symptoms of an airway obstruction as evidenced by "can't breathe or speak." MD-A stated if R66 had been sent to the ER nothing could have been done however, sending the patient for an endoscopy was appropriate. MD-A explained that when he worked as the ER MD he would come to the facility and do a face to face with the patient and then send to endoscopy. He stated the eLTC doctor could have given an order to send R66 to the ER and/or hospital. MD-A stated when he'd reviewed the incident regarding this patient, he had not been aware that the eLTC MD had not seen the patient "face to face" to conduct an assessment, since the video equipment had not been turned on. MD-A could not explain why R66 had not been evaluated 'face to face' by eLTC per video as that was the facility's protocol. MD-A stated there possibly would have been a different response if R66 had been seen by the eLTC MD. In addition, in an email document provided by the facility to surveyors dated 6/29/16 at 2:55 p.m., from MD-A to the nursing home administrator, MD-A had written, "E LTC was called but not on camera so technically no F2F (face to face) consult was made [for R66]." The email was part of the review of the case MD-A had conducted in response to a request by the facility.	F 309		

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The director of nursing (DON) was interviewed on 1/24/17 at 5:07 p.m., the DON stated that for acute medical conditions, "if it is an emergency, they are seen emergently in the ER." The DON was unaware of any requirements for a resident to be seen face to face prior to an emergency room transfer and provided a list of residents seen in the emergency department from the long-term care center within the last 12 months.

On 1/25/17 at 8:34 a.m., an interview was conducted with the emergency department (ED) manager. The ED manager stated she could not recall the incident for R66 on 6/17/16. However, the ED manager stated the eLTC doctor would tell the nurse at the nursing home when to present a resident to the ER, and that they (eLTC) are trusted to determine when the resident needed to be seen in the ER. The ED manager further verified that a life threatening crisis would require being seen immediately and referenced a CMS (Centers for Medicare/Medicaid Support, a federal regulation division) guideline that is utilized to determine if a resident is seen immediately without first utilizing eLTC. The EDM confirmed that in the instance of a provider giving an order for patient be seen in ER, "the expectation would be for immediate transport."

Registered nurse manager (NM)-A, was interviewed on 1/25/17, at 10:20 a.m., NM-A stated the intent for the eLTC program was for residents to get as much workup done as possible while in the nursing home for non-emergent situations. NM-A stated not being aware of a facility policy that would have required a face to face visit with the MD prior to emergency room transport. NM-A stated the facility had used eLTC for a few years, that events

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are reviewed periodically, and that nurses are educated/oriented to eLTC processes by other charge nurses. In addition, NM-A recalled that eLTC had been contacted when R66 felt like there was "chicken stuck in throat." NM-A said FM-1 was with R66 and her vital signs had been stable. NM-A also stated, "if a simple intervention here is not going to work, the telemonitor wouldn't work." NM-A confirmed the food bolus put R66 at a higher risk of aspiration.

The administrator was interviewed on 1/25/17 at 3:21 p.m., regarding the medical incident with R66 on 6/17/16. The administrator stated if the situation was "emergent" for R66 than she would have gone immediately to the emergency room. The administrator said the decision about whether a medical situation is emergent or non-emergent was determined by the nurse's assessment of the resident. When the surveyor informed him that a face to face had not been completed by eLTC, the administrator confirmed it was an option to talk to eLTC by phone rather than by video. The ADM verified that the expectation for RN-A to ask for a face to face visit when given an order by MD-B would have been the correct protocol. The ADM indicated that if MD-B had refused to do a face to face visit, there is an algorithm for the nurse to follow. The ADM did not know why R66 had not been sent to the ER when there was an order from to do so by MD-B. When presented with potential issues of aspiration, airway management, and discomfort, the ADM stated she had not been in the facility and had not seen the resident.

During a follow up interview with RN-A on 1/26/17 at 8:22 a.m., RN-A stated he remembered having received a call on the way over to the hospital

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with R66 on 6/17/16. RN-A stated he thought the call had been from the DON, and stated he had been directed not to take R66 to the ER, so he had returned R66 to her room at the facility.

On 1/26/17 at 9:24 a.m., the DON confirmed she had worked on 6/17/16 however, denied having called RN-A to stop the transfer of R66 to the hospital.

On 1/26/17 at 10:03 a.m., RN-B was interviewed and stated eLTC was used when a resident's provider from Avera was not available. RN-B stated that if the resident used one of the other clinic's physicians, the outside provider ACMC was called first. RN-B said that with either provider group, the doctor did a workup or told the staff to use eLTC, depending on the situation.

On 1/26/17 at 10:20 a.m., an interview was conducted with CM-A who verified having worked on 6/17/16. CM-A also denied having called RN-A with directions to return the resident to the facility. CM-A further stated, "there was discussion surrounding the incident after it had occurred and a root cause analysis was completed. The medical director did not feel there was risk of aspiration during that discussion and I did not feel it was my place to second guess that."

On 1/27/17 at 11:23 a.m., the DON and administrator stated that RN-A would have been given the eLTC orientation at the time it was implemented, and should have had the basic orientation checklist in his file. The DON again stated she felt the right thing had been done for R66. The administrator then stated that if R66 had been actively choking with distress, RN-A would have taken R66 to the ER. Also the

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administrator and director of nursing were asked for eLTC process training was requested for RN-A. However, none was provided and none was found in RN-A's personal record when reviewed.

Registered nurse (RN)-A was interviewed on 1/27/17 at 12:33 p.m. regarding eLTC education. RN-A said he had received training regarding a change in the protocol for when to use the eLTC system the prior evening, 1/26/17 after the facility had been informed of the serious concern about R66's 6/17/16 incident.

Review of a document titled Physician Services Agreement (undated) for the medical providers to sign to be designated as the resident's attending physician for each resident included: "Supervising the medical care of [name for resident] means I will: [bullet six] Complete a face to face visit before ordering that a resident be transferred to an Emergency Department or to the hospital (for non-life threatening, non-emergent situations)."

An Avera Marshall Regional Medical Center consent form, was requested for R66 for authorization of eLTC use, the consent form was not provided.

A policy for management of a choking resident, and a policy for the Heimlich maneuver was requested during the survey. A second request was made by e-mail to the DON, who responded that the facility did not have a policy specific for a choking resident, or use of the Heimlich maneuver.

R116's discharge record was reviewed. A Discharge to NH(nursing home)/AL(assisted

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living) summary dated 12/21/16, indicated R116 had a previous medical history including: hypertension, atrial fibrillation, pacemaker placement, and arthritis. The discharge summary further identified a primary problem of cardiac amyloidosis (a disease that occurs when a substance known as amyloid builds up in the heart, which causes it to get increasingly stiff and deteriorates the pumping function), hyperkalemia and poor appetite, and indicated R116 was a full code for resuscitation status.

R116's admission MDS dated 12/28/16, identified a Brief Interview for Mental Status score of 13 indicating R116 had intact cognition, and had expressed verbal symptoms of pain within the look back. A subsequent discharge tracking MDS, dated 1/2/17 indicated R116 had died in the facility.

An Avera Marshall Regional Medical Center consent form, dated 12/22/16 indicated R116's family had authorized use of eLTC services in the absence of her primary physician or his/her designee.

An Urgent Care Telehealth Encounter Note dated 12/23/16, indicated R116 had been seen by eLTC due to moderate to severe chest pain which had started around 3:30 p.m. on that date. The note indicated R116 had "acute chest pain, certainly could beunstable angina or NSTEMI (non-st segment elevated myocardial infarction)." In addition, the note indicated staff were to obtain a BNP (lab used to check severity of congestive heart failure), give 40 milligrams of Lasix (a diuretic) intravenously, to stop R116's oral metolazone (another diuretic), and to provide tramadol (a pain reliever) now, and that pending a troponin level (laboratory value of a complex of proteins integral to contraction of the heart muscle that is elevated after a heart attack) could

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consider Nitroglycerin or morphine for pain control. The note further indicated R116's family was planning on having the resident stay at the nursing home but had decided to transfer her to the emergency room so her case had been discussed with the local emergency room physician. The diagnosis was listed as chest pain, unspecified.

R116's nursing progress notes revealed the following entries:

On 12/23/16 a notation was entered by RN-A 5:24 p.m.: R116 had complained of epigastric/chest area pain this afternoon around 3:30 p.m. She had rated the pain at an 8 on a 10 point scale (10 being the most severe pain). R116 had been administered Maalox (an antacid) and Zofran (a medication for nausea) by RN-A. After 20 minutes, R116 had rated her pain at a 10 out of 10 and an on-call physician was contacted to see R116 but was unable to be reached. As a result, eLTC (a telemedicine service) had been contacted for a workup. An EKG (electrocardiogram), a chest x-ray and review of labs was done. The note indicated pain medication administered and family wished to keep R116 in the nursing home but would consider ED transfer pending lab results and worsening of condition. The note indicated eLTC would be notified as test results came in, that R116 was lying quietly in bed with family at bedside stating the pain was a little better. Will continue to monitor.

R116's EKG results, dated 12/23/16 at 4:54 p.m. indicated a ventricular-paced rhythm, no further analysis was obtained due to the fact R116 had a pacemaker.

R116's medication administration record (MAR) at the facility revealed R116 had received 30 milliliters of Maalox at 3:40 p.m., a dose of

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tramadol at 11:03 a.m. and Tylenol tablets, 650 milligrams orally on 12/23/16. The MAR did not reflect any intravenous Lasix administration, nor any further medication being given to R116 to treat chest pain.
A subsequent nursing progress note indicated: On 12/23/16 at 7:42 p.m. a notation was documented by licensed practical nurse (LPN)-E: Family requested R116 be transferred to the emergency room at 6:00 p.m. RN notified eLTC doctor. R116 was transferred at 6:10 p.m.
R116's ED nursing progress notes indicated she'd arrived in the ER at 6:26 p.m. on 12/23/16 after having only been at the nursing home a couple of days. The notes further revealed that at 7:09 p.m. R116 was found to have a troponin level of 0.159 (indicative of heart muscle damage or increased cardiac risk). The plan of care was discussed with R116 and her family and at 7:49 p.m., R116's family indicated they wanted R116 to be transferred to an outside facility for further treatment.
R116's emergency department (ED) visit note dated 12/23/16, authored by medical doctor (MD)-G indicated R116 had started having epigastric pain at 2:00 p.m. after physical therapy, and family and the E care doctor were concerned of a possible MI (myocardial infarction, a term for heart attack) so R116 had been sent to the ED for evaluation and management. R116 complained of pain rated at a 10 out of 10 upon ED admission which was substernal. Modifying factors that were not tried included analgesics, antacids, aspirin, breathing, coughing, eating, exercise, lying down, movement, nitroglycerin, other, oxygen, palpation and rest.
R116's laboratory work revealed that the basic metabolic panel (measuring kidney function and electrolyte function) and a troponin were not

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F 309	Continued From page 35 collected until 6:26 p.m., after R116 had been transferred to the emergency room. A follow up nursing home progress note entry indicated the following information: On 12/24/16 at 4:18 a.m. documentation by LPN-F included: At 8:00 p.m. (on 12/23/16), R116's family came back to her room to get her belongings, stating R116 was being transported to the hospital in Sioux Falls to receive treatment. Family stated this was due to R116 sustaining heart damage and a bed hold was signed per family, as R116 was too upset to make any decisions at this time. R116's Avera Heart Hospital of South Dakota history and physical dated 12/23/16 at 11:16 p.m., listed a chief complaint of "?" and indicated R116 had been admitted from the ER in Marshall, with concerns of an elevated troponin level and electrolyte imbalances. R116 had received 4 milligrams of morphine to control chest pain along with a heparin bolus (anti-clotting medication) and a nitroglygerin drip prior to transport to South Dakota. Lasix was recommended to help with fluid overload state and to get her potassium level down. A follow-up visit note at the Avera Heart Hospital indicated R116 was being given additional Lasix to decrease her potassium levels and that discharge was anticipated back to the nursing home as family was considering hospice care. During interview on 1/24/17 at 5:07 p.m., the nursing home DON was interviewed about when to use eLTC. The DON stated, "If it is an emergency, they are seen emergently in the ER." The DON was unaware of any requirements for a resident to be seen face to face prior to an emergency room transfer and provided a list of residents seen in the emergency department from long-term care within the last 12 months.	F 309		

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F 309	Continued From page 36 The list included R116. During interview on 1/25/17, at 8:17 a.m. RN-A verified the facility used eLTC services on the weekends and after hours. The facility policy stated that if the resident had an Avera doctor and they were unavailable and needed to be seen, then eLTC would be contacted. RN-A further stated "if you can not get ahold of someone's provider eLTC may also be used." RN-A stated signs of a stroke or a heart attack would warrant nursing judgment to send them directly to the ED. RN-A stated he'd thought the laboratory staff had come over to draw labs on R116 right away, and could not recall when or what type of pain medication R116 had received at the time of her chest pain. RN-A stated he recalled trying to reach an on call doctor regarding R116, however was unable to reach him so used the eLTC doctor. RN-A could not recall informing R116's family of their options at the time for medical care however stated he thought the eLTC doctor had done this. RN-A stated the eLTC program had been in place at Avera Marshall for at least a year or two, and there had been people from Sioux Falls that had come over to educate licensed staff on the equipment and program. In addition, RN-A stated a binder of pathways was located at the nursing desks which was available for staff to reference. During interview on 1/25/17, at 9:22 a.m. R116's family (F)-2, stated her mother had cardiac amyloidosis and that the options were not clearly explained to her regarding her mother's treatment at the time her mother had started having chest pain. F-2 stated the family had signed a consent for eLTC services however, had thought there was no doctor available to take	F 309		

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care of their mother at the time she started experiencing chest pain. F2 stated she was unaware her mother could have been sent to the ED right away. F-2 stated she was not sure herself why her mother had not been sent over right away, and that basically as soon as the family was presented with this option they did so. Additionally, F-2 stated her mother had wanted to go to the ED, and had experienced very severe chest discomfort during this time.

During interview on 1/25/2017, at 10:03 a.m. RN-B stated eLTC was used when a resident's provider from Avera was not in. If the resident used one of the Affiliated Community Medical Clinic (ACMC) doctors, then the outside provider was called first. Either way the doctor did a workup or told the staff to use eLTC, depending on the situation. There was an eLTC book on the nursing station with a reference link on the computers as well.

During interview on 1/25/17, at 10:20 a.m. the RN nurse manager (NM)-A stated the intent of the program was for residents to get as much workup done in the nursing home for non-emergent situations, not symptoms of a heart attack. NM-A indicated serious chest pain would have qualified as an emergent situation warranting transport immediately to the ED. NM-A was not aware of any facility policy that would have required a face to face visit with a doctor prior to emergency room transportation. NM-A was asked what type of clinical conditions/residents she would consider warranting transport to the emergency room vs. using eLTC for and stated "Her [R116]," after reviewing R116's clinical record for 12/23/16. NM-A reviewed the eLTC pathway book and stated new, acute chest pain which was

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unrelieved would warrant immediate ED transfer according to the pathway.

During interview on 1/25/17, at 11:55 a.m. the medical director (MD-A) stated that the goal of the eLTC program was to see a provider timely. eLTC providers were available via telephone, or camera, and could order labs, tests, medications, intravenous lines and x-rays. MD-A explained that the facility had a grant, and they were trying to utilize the service to support immediate access to the doctor. MD-A revealed that the service was not appropriate if there was an acute change in care, or the resident had an emergency, with airway obstruction, breathing difficulty or cardiac arrest. MDS explained that there were protocols, pathways on the units for the nurse to follow, and stated that "a lot of the situations are nonemergent." When presented with an example of a patient exhibiting signs of a heart attack such as chest pain rated at 8 out of 10, escalating within the hour to 10/10, who was given maalox for indigestion, and Zofran for nausea, one dose of Tylenol for pain, he explained that he would get the quickest person there. "If the person indicated they wanted to go to the emergency room (ER), then it would be appropriate to send them to the ER. MD-A further said that the doctor must do a face to face, and he "believed" the requirement was from CMS, but was not certain. In this situation he confirmed that he was disappointed that the patient (R116) had not been given a stronger medication for pain. MD-A stated there had been hard feelings between the nursing home and one of the other medical providers resulting in some legal issues.

During interview on 1/25/17, at 3:21 p.m. the administrator stated she felt eLTC use was

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appropriate for someone reporting severe chest pain rated a 10 out of 10 and was unable to state what would constitute an emergent versus non-emergent situation in which eLTC would not be used and the resident brought directly to the ED.

During additional interview on 1/25/17, at 1:41 p.m. MD-A (the medical director and also R116's primary physician), stated R116 had an unusual cardiac condition and had been admitted late in the day on 12/21/16 to the facility. R116 had a pacemaker inserted which was not working effectively and was very weak. The medical director stated he had not had time to fully discuss R116's condition with family and had not found out about her episode of chest pain as he had a day off on 12/23/16 until he returned back on duty. The medical director stated the eLTC providers were used after hours for on-call coverage for his residents. The medical director indicated R116's condition was terminal, however wished someone had called him on 12/23/16 and that she "probably should have" gotten pain control from the eLTC physician such as morphine or nitroglycerin on board right away. The medical director stated he did not feel the visit had been very effective in managing R116's symptoms.

A facility policy entitled Physician/Medical Services LTC (long term care), Effective: 11/2011 and Expiration: 11/2017 (page 1 of 4) included:

"F. Complete a face to face visit before ordering a resident to be transferred to an Emergency Department or to a hospital. This requirement is for acute changes in medical condition of a resident. Face to face visit is not required if a

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F 309	Continued From page 40 resident is going to a hospital for a scheduled appointment, and/or a scheduled out patient procedure, or if going to the ED [emergency department] for an emergency, life threatening condition (as specified later in this policy)." The Physician/Medical Services LTC algorithm on page 1. (Undated) included "Change in resident's medical condition, requiring physician intervention (arrow to next box) "Emergency, life threatening medical condition?" (If Yes arrow to next box) "Resident taken to ED [emergency department] for evaluation" (if No arrow to next box) "Resident consent to utilize eLTC present on resident's chart?" (If Yes arrow to next box) "eLTC contacted." The immediate jeopardy that began on 6/21/16, was removed on 1/26/17, when the facility implemented the following interventions: Reviewed and revised R66's care plan to include diet order information and precautions associated with esophageal narrowing/stricture; Reviewed records of all resident transfers to the emergency department (ED)/hospital/same-day surgery which were unplanned in the previous 12 months; Updated care plans of affected residents accordingly; Reviewed and revised their physician care services and resident care policies regarding the use of eLTC; Updated their resident transfer process procedure and process maps; Implemented a log to track unplanned transfers and changes of resident conditions; Audited resident records for which eLTC had been utilized prior to hospital/ED visits; and verified all licensed staff had been educated regarding these changes.	F 309		
F 312	483.24(a)(2) ADL CARE PROVIDED FOR	F 312		3/8/17

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F 312 SS=D	Continued From page 41 DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide facial shaving services to meet the grooming needs for 1 of 3 residents (R54) reviewed for activities of daily living (ADL's). Findings include: On 1/23/17, at 4:22 p.m. R54 was observed seated in recliner in her room. R54 had long unshaven facial near her chin along the jawline on the right side of her face. The hairs were approximated 1/4-1/2 inch in length. The facial hair continued to be present all days of the survey from 1/23/17 through 1/27/17. R54's annual Minimum Data Set (MDS) assessment dated 1/4/17, included a Brief Interview for Mental Status (BIMS) score of 6/15, indicating severe cognitive impairment, and required extensive assistance with personal hygiene. R54's diagnoses included hemiplegia (paralysis on one side of the body) following CVA (cerebrovascular accident/stroke) affecting the right dominant side. The care plan revised 1/7/17, for R54 identified a personal care activity of daily living (ADL) goal as noted: It is very important to my mental health that I look well dressed/groomed daily. Interventions included requiring assist of staff for	F 312	ADL cares for identified residents reviewed with assigned care givers. On-going compliance: staff education provided on resident care planning and grooming processes including the appropriateness of hygiene cares for residents who are unable to carry to ADL's and are required to receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene during the March staff meetings. Tracking tool will be used to monitor and track residents on a monthly basis for appropriate hygiene and grooming practices. Results of monitoring activities will be added to the LTC quality scorecard and reviewed at monthly LTC quality committee meetings.	

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F 312	Continued From page 42 all grooming needs. When interviewed on 1/26/17, at 2:37 p.m. nursing assistant (NA)-A stated residents need to have their own shavers if wanting to be shaved. NA-A confirmed R54 did not have her own shaver nor had asked to be shaved. When interviewed on 1/27/17, at 11:02 a.m. NA-A confirmed R54 had long unshaven facial hair mainly on the right side of face, explaining she was aware of the facial hair as had questioned R54 approximately 6 months ago whether she desired to be shaved; however, R54 declined. NA-A also stated R54 did not own a personal shaver and if she desired to have one, the family would need to purchase a shaver. NA-A verified that R54 preferred to look nice (requested to wear a necklace daily) and had a hair appointment every Monday after her bath. Upon entering R54's room with the surveyor present, NA-A asked R54 whether she preferred to have her facial hair removed if a shaver was purchased for her use. R54 responded, "Yes" and nodded her head up and down. After leaving the room, NA-A approached administrative assistant (AA)-A at the front desk to inform AA-A of R54's need for a personal shaver. When questioned who was responsible for acquiring the shaver, AA-A stated R54's family would have to purchase it unless approval was given to use funds from R54's personal funds account for staff to purchase a shaver. When interviewed on 1/27/17, at 11:24 a.m. AA-A confirmed R54's family would be responsible for providing a shaver and/or approval to utilize personal funds for staff to purchase one. AA-A stated in the past the beauty shop used to have a	F 312		

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F 312	Continued From page 43 cleanable razor which was used for resident's without a personal shaver. but was unaware whether this was a current option. AA-A stated residents usually were admitted with their own personal shavers but she would follow up with the beauty shop. When interviewed on 1/27/17, at 11:27 a.m. clinical manager (CM)-B verified residents were required to have their own razor. CM-B stated in the past the facility had community shavers available for resident use but they were not always thoroughly cleaned. Due to the risk of infection if not thoroughly cleaned, residents were now required to purchase their own personal shavers. CM-B also confirmed there were no extra shavers available for resident use at this time. CM-B verified the facility was responsible to meet R54's grooming needs per the plan of care. When interviewed on 1/27/17, at 11:50 a.m. AA-A confirmed the beauty shop did have a shaver available for residents who did not have their own personal shaver to meet their grooming needs. The policy titled, Resident Quality of Life dated 1/2016, included: Grooming: staff will recognize and obtain resident preference as to how resident wishes to be groomed. Grooming includes the following: Facial hair: how resident likes to be shaved. If a woman, does resident like to have hair removal.	F 312		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility.	F 318		3/8/17

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F 318	Continued From page 44 (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a splint was applied to the right hand to prevent further development of contractures (permanent shortening of a muscle or joint preventing normal movement) for 1 of 1 resident (R45) reviewed for range of motion (ROM). Findings include: Review of R45's quarterly Minimum Data Set (MDS) assessment dated 1/11/17, identified R45 as comatose with a diagnosis of traumatic brain injury (TBI). The MDS identified R45 as requiring total assistance for bed mobility, transfers, dressing and personal hygiene. It further identified R45 as having impairment on both sides of upper extremities with functional limitation in range of motion. Review of R45's care plan last revised 1/16/17, identified R45 wore a hand splint in right hand/arm 6-8 hours per day and a carrot splint at all times in left hand. The care plan further directed staff to see therapy directions in R45's room for splints/braces. R45's current undated splint order stated: right hand forearm	F 318	Splint application for identified resident reviewed with assigned staff. On-going compliance: Staff education will be provided during Marsh staff meetings on care planning policies including ensuring residents with limited range of motion receives appropriate treatment and services to increase range of motion and or to prevent further decrease in range of motion. Staff care sheets will be updated to reflect splint or brace needs of 100% of residents who have orders for splints or braces. Nurse Mangers will monitor 10% of residents monthly for following of care plans including use of splints, braces, and/or ROM. Tracking of care plan compliance including use of splints, braces, ROM exercises will be added to department quality scorecards and reported and reviewed at monthly LTC Quality Committee meetings.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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splint/brace on for 6-8 hours per day....on 6:00 a.m. off at 2:00 p.m.

On 1/24/17, at 9:32 a.m. R45 was observed lying in bed with a carrot splint in place to left hand. No splint was on right hand at this time. Nursing assistant (NA)-B stated R45 only wore a carrot splint to his left hand, and did not wear or utilize any other splint devices for right hand.

On 1/24/17, at 2:06 p.m. licensed practical nurse (LPN)-A was observed to apply a splint to R45's right hand. LPN-A stated R45 was suppose to have the splint on but NA-B must have forgotten to apply earlier with morning cares by the nursing staff.

During interview on 1/24/17, at 2:07 p.m. both NA-E and NA-D stated they were only aware of R45 wearing a carrot splint to left hand; not aware of any other devices or splints for right hand.

On 1/26/17, at 10:12 a.m. ROM exercises were completed to both upper extremities by NA-C and NA-D with a carrot splint placed to the left hand. However, no splint was applied to R45's right hand following the ROM.

On 1/27/17, at 8:07 a.m. R45 was lying in bed dressed and groomed; no splint to right hand. At 9:21 a.m. NA-G verified R45 had a carrot splint in place on left hand but no other splint was worn by R45. At 9:27 a.m. NA-F also indicated R45 did not wear a right hand splint.

When interviewed on 1/27/17, at 10:22 a.m. LPN-C verified R45 did not have a right hand splint applied as ordered and indicated that splint instructions were not posted in R45's room as

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F 318	Continued From page 46 directed on the plan of care. During interview on 1/27/17, at 10:23 a.m. the director of nursing (DON) confirmed she expected staff to follow the plan of care and verified R45 was to wear a right hand splint on 6-8 hours per day as ordered. During interview on 1/27/17, at 11:33 a.m. the certified occupational therapist assistant (COTA) stated splints are ordered for residents to prevent further contractures and when therapy gives recommendations and schedules for splint use they expect nursing to follow it. A facility policy related to following plan of care was requested but not provided.	F 318		
F 497 SS=D	483.35(d)(7) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE (d)(7) Regular In-Service Education 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. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete performance reviews every 12 months for 2 of 7 nursing assistant (NA-H, NA-I) personnel files reviewed and failed to ensure at least 12 hours of in-service training had been completed for 3 of 7 nursing assistant (NA-F, NA-H, NA-I) training records reviewed during the extended survey. This had the	F 497	Incomplete performance reviews will be completed by 3/31/17. On-going compliance: Human Resource policy on performance reviews will be reviewed and updated to reflect expectations of timely performance reviews for all employees. Education to leaders on policy expectations (leaders	3/8/17

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F 497	Continued From page 47 potential to affect all 72 residents in the facility. Findings include: Nursing assistants (NA)-H personnel file was reviewed on 1/26/17, and indicated a hire date of 10/9/15. The personnel file lacked evidence that any performance evaluation had not been conducted. In addition, the Training Records from 1/1/16 through 12/31/16, lacked evidence that NA-H had completed any in-service/continuing education hours during 2016. NA-I's personnel file was reviewed on 1/26/17, and indicated a hire date of 9/29/14. The personnel file indicated the most recent performance evaluation was completed on 12/4/15 (13 months prior). No performance evaluation had been completed for 2016. In addition, a review of the Training Records from 1/1/16 through 12/31/16, noted NA-I had only completed 9.04 hours of continuing education in 2016 instead of the required twelve hours. NA F's personnel file was reviewed on 1/26/17, and indicated a hire date of 12/15/14. A review of NA-F's Training Records from 1/1/16, through 12/31/16, noted NA-F had only completed 6.25 hours of continuing education in the last year. The file lacked evidence of the NA having completed twelve hours of continuing education in the last year. When interviewed on 1/26/17, at 9:59 a.m. talent acquisition specialist (TAS)-A verified that NA-H and NA-I did not have performance reviews completed at least once every 12 months. During interview on 1/26/17, at 2:40 p.m.	F 497	assigned to complete performance reviews). Process placed to update managers, director and administration with overdue performance evaluations. Overdue evaluations will be sent as a reminder on a daily basis via email until evaluations are completed and signed off by employee and manager(s). Process placed to update managers via email alert for staff who are overdue in completing mandatory and required education. Human Resources department will be notified of overdue performance evaluations for tracking of timely completion. Untimely completion of performance reviews will be forwarded to the leader's respective manager for follow up. Managers will track employee compliance with completion of mandatory education and will follow up with employees during monthly rounding. Employees who are unable to complete mandatory education will be offered the link to complete the online CBL's remotely and will be paid for their time.	

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F 497	Continued From page 48 administrative assistant (AA)-A verified that NA-F, NA-H and NA-I did not have 12 hours of continuing education from 1/1/16 through 12/31/16.	F 497		
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as	F 520		3/8/17

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F 520	Continued From page 49 such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA)committee identified, evaluated and developed a plan to address concerns with regard to protocols for use of eLTC (a telemedicine service available in the facility) and face to face visits being conducted for emergent acute changes in condition. This deficient practice had the potential to affect all 72 residents in the facility. Findings include: Refer to F309 - Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. This resulted in immediate jeopardy for R66, who experienced actual harm due to delayed treatment for an esophageal obstruction resulting in discomfort, esophageal irritation and risk of aspiration pneumonia/airway compromise as well as actual harm for R116, who had a history of cardiac disease and experienced delayed treatment for severe chest pain. A graph entitled eCARE Senior Care - Avera	F 520	Change in condition events added to LTC Quality Committee and scorecard. On-going compliance: education provided to nursing staff on completion of change in condition/transfer form to be completed on 100% of residents who present with a change in condition or those requiring a transfer to ED/hospital/SDS. Forms forwarded to DON or designee to be reviewed for appropriateness of care no later than the next business day. Change in condition forms/transfer forms will be reviewed by DON and LTC medical director each week for appropriateness and timeliness of care. Summary of findings will be reported on a monthly basis to the LTC Quality Committee meetings.	

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Morningside Heights Care Center for the dates of 5/2016 through 12/2016 showed a total for this six month period of 37 urgent care video encounters, with a large percentage of telephone and video encounters occurring between the hours of 9:00 a.m. and 3:00 p.m.

During interview on 1/25/17, at 11:55 a.m. the medical director (MD)-A for Morningside Care center, stated the goal of the eLTC program was for residents to see a provider timely. eLTC providers were available via telephone, or camera, and could order labs, tests, medications, intravenous lines and x-rays. MD-A explained the facility had a grant and were trying to utilize the service to support immediate access to the doctor. MD-A revealed the service was not appropriate if there was an acute change in care, or the resident had an emergency; with airway obstruction, breathing difficulty or cardiac arrest. MDS explained there were protocols, pathways on the nursing units for the nurse to follow, and stated that "a lot of the situations are non-emergent." When presented with an example of a patient exhibiting signs of a heart attack such as chest pain rated at 8 out of 10, escalating within the hour to 10/10, who was given Maalox for indigestion, and Zofran for nausea, one dose of Tylenol for pain, he responded that he would get the quickest person there, "If the person indicated they wanted to go to the emergency room (ER), then it would be appropriate to send them to the ER". MD-A further stated the doctor must do a face to face and he "believed" the requirement was from CMS, but was not certain. In this situation he confirmed he was disappointed that R116 had not been administered a stronger medication for pain. In addition, MD-A confirmed he was present in

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the facility three days/week and attended the QAA meetings. MD-A stated improper use of the eLTC system had not been reviewed at the QAA meetings and wished staff would call him more so he could be aware of what medications the eLTC providers were starting on his residents.

During interview on 1/25/2017, at 3:21 p.m. the administrator (who was identified as the facility's primary QA committee contact) stated for emergent situations the resident should go directly to the ER prior to a face to face assessment, however did not feel R66 or R116 experienced emergent health conditions The administrator stated use of the eLTC system was reviewed upon initial orientation and there had been training in 8/2016 on new additions to the program requirements that had been added. There had not been a QA review specifically with regard to whether the system was being used appropriately for non-emergent situations.

During interview on 1/27/17, at 11:23 a.m. the director of nursing (DON) stated sources of quality improvement ideas included previous survey citations, behavioral management issues, antipsychotic medication reduction recommendations and incident reports. Physician services had been a topic of discussion within the last year, however concerns with eLTC monitoring being used for conditions that might be emergent vs. non-emergent had not. The facility had implemented the eLTC as a method to reduce acute care transfers and repeat trips to the emergency room. The administrator was also present during this interview, and stated she did not feel anything had been done wrong with regard to R66 and her incident of a food bolus obstruction on 6/17/16. Although R66 had not

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been taken to the emergency department (ED) as directed by her primary physician, the concern had not been addressed via the QA committee, rather MD-A had done a chart review. The administrator further stated if R66 had not been breathing there would have been an event analysis done.

The facility policy entitled Avera Morningside Heights Care Center Quality Assurance and Performance Improvement (QAPI) Committee Design and Scope or Service, last revised 4/15 indicated the program would be ongoing and comprehensive, and address resident care transitions, aiming for safety and high quality while emphasizing autonomy and choice in daily life for residents. The policy indicated the Vice President of Resident care Services will be accountable for the QAPI program.

The facility policy entitled Avera Morningside Heights Care Center QAPI Committee Design and Scope or Service, last revised 4/15 indicated the LTC (long-term care) will have a quality committee. The committee will identify quality deficiencies and develop and implement plans of action to correct these deficiencies. The LTC Quality Committee will report to the Quality Committee of the Board. A section entitled Feedback, Data Systems and Monitoring indicated the committee will develop systems to monitor care and services, obtaining data for a variety of sources. Data will be obtained from staff, patients, families and others as appropriate, performance indicators, survey findings, adverse events and other sources as appropriate.

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Avera Marshall Regional Medical Center Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	EPOC	

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

Electronically Signed | 02/22/2017

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 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been,or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Avera Marshall Regional Medical Center Nursing Home was constructed as follows: The original building was constructed in 1963, it is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2004 Addition is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an attached hospital by 2-hour fire rated wall assemblies. The building has a fire alarm system with smoke detection in the corridors, which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke detection. The facility has a capacity of 76 beds and had a census of 72 at	K 000		

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K 000	Continued From page 2 time of the survey. Due to the extensive renovation of the original 1963 building, the entire facility was surveyed as one building at NFPA 101 (2012) Chapter 19 Existing Health Care Occupancies. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that spare fire sprinklers were kept in the sprinkler box at the sprinkler riser in accordance with NFPA 13. This deficient practice could affect 5 of the 75 residents.	K 351	Contacted Building Sprinkler on 1/25/17. Informed him that we needed two of each type of sprinkler heads in the sprinkler box. Personnel came added required sprinkler heads on 1/31/17. Label added to front of box with a list of the required heads for quick reference.	1/31/17

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K 351	Continued From page 3 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 01/24/2017, observation revealed, that at least 2 replacement fire sprinkler heads for each style that is in service at the facility were not in the Replacement Sprinkler Head Box. This deficient practice was verified by the Facility Maintenance Director.	K 351		
K 711 SS=F	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a	K 711		2/16/17

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AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

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K 711	Continued From page 4 copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to maintain a Evacuation and Relocation Plan according to the 2012 Life Safety Code.This deficient practice could affect 72 of the 72 residents Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 01/24/2017, documentation review revealed the Emergency Fire Plan needs to be updated to ensure all the requirements of the 2012 Life Safety Code are addressed, specificly, to include language that staff will call 911 in the event of smoke and/or fire.	K 711	Updated Fire Response and Evacuation plan for Morningside Heights. Placed a copy of updated plan in the Book of Business. Added item 6 to procedure section of plan: staff member to call 911 to confirm fire call has been received.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**01/24/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET MARSHALL, MN 56258**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 711	Continued From page 5 This deficient practice was verified by the Facility Maintenance Director.	K 711		
K 781 SS=E	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a written and current Space Heater Policy.This deficient practice could affect 72 of 72 residents. Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 01/24/2017, documentation reviewed revealed that the Facility does not have a written Space Heater Policy that is specific to the Avera Marshall Morning Side Heights. This deficient practice was verified by the Facility Maintenance Director.	K 781	New policy on space heater use in Morningside Heights Care Center developed. Copy of new policy placed in Book of Business	2/15/17
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste	K 918		2/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 6 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of generator maintenance and testing are maintained and readily available. This deficient	K 918	Updated monthly Emergency Generator log to include transfer time. Copy of updated log placed in log book and forms file also updated with new form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 7 practice could affect 72 of 72 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM	K 918		

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K 918	Continued From page 8 on 01/24/2017, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test. The transfer time of how long it takes the emergency generator to assume power is not being recorded. This deficient practice was verified by the Facility Maintenance Director.	K 918		

Avera Marshall Regional Medical Center

Effective:	*05/2006*
Approved:	*02/2017*
Last Revised:	*02/2017*
Expiration:	*02/2018*
Owner:	*Kevin Schroeder: Environmental Services Director*
Policy Area:	*Emergency Preparedness*
Applicability:	*Avera Marshall Regional Hospital*

Fire Response and Evacuation Plan for Morningside Heights Care Center

POLICY:

Emergency response to fire and evacuation requires careful planning and execution to provide for the utmost safety and security of the residents and staff in the event of fire or other disaster.

PURPOSE:

To provide for a systematic means of evacuation egress that compliments the organization's Fire Emergency/ Code Red Response Policy.

PROCEDURE:

a. In the event of fire, the Fire Emergency (Former Code Red) Response Plan will be enacted and followed. Specifically, the LTC will respond as follows:

When a **smoke detector** is activated in a resident room the following should take place:

i. The detector sends a call to the nurse call system, it is placed to all staff audio stations (stations at the nurse stations in corridor, shower rooms, utility rooms) because it is a emergency call.

ii. A staff member must go to the room that is in alarm and verify whether or not it is a real fire.

iii. In the event of a real fire, the staff member should perform R.A.C.E. procedures, rescue the resident by removing them from the room (RESCUE) and then close the door when exiting (CONTAIN) and communicate with staff/facility "FIRE ALARM ALERT". **At this time team work is essential** . All staff will start helping with clearing residents from affected smoke compartment. Clear all corridors of any equipment (i.e. medicine carts, shower chairs, etc.) into vacated resident rooms/utility rooms or lounges

iv. A staff member should pull the pull station (ALERT) when "FIRE ALARM ALERT" is being communicated.

v. Transmission of fire alarm is through a phone line to Marshall Municipal Utilities (MMU) dispatch then transmits to the Marshall Fire Department.

vi. A staff member should call 911 to confirm fire call has been received and the fire department is in route.

vii. A staff member must then move the resident to a safe smoke compartment. A smoke compartment is created on each side of the fire (double) doors in the corridors; so the resident must be moved to the other side of a fire (double) door in the corridor away from the fire.

viii. Extinguish the fire if possible (EXTINGUISH). If this is not possible, keep the door closed and let sprinkler system do its job and wait for fire department.

ix. Make sure all other residents in that smoke compartment are evacuated (EVACUATE) to a safe smoke compartment as follows:

1. The facility will be evacuated as follows:

a. Evacuation placards are placed in several places throughout the facility.

b. The placards identify the location the individual is in and the closest defined smoke compartment barrier.

c. The resident is transported to a safe smoke compartment nearest to the current location and away from the fire.

d. On first floor, there are 3 designated smoke compartments – these are identified as the yellow fire evacuation zone, the green fire evacuation zone, and the blue fire evacuation zone.

e. On ground floor, there are four designated smoke compartments, - the yellow fire evacuation zone, the green fire evacuation zone, the red fire evacuation zone, and the blue fire evacuation zone.

b. In addition to the above response, the incident command system will be enacted to lead the evacuation plan if appropriate.

i. The incident commander or designated leader will create an immediate labor pool of all available staff in the long term care facility AND request assistance from all other departments of Avera Marshall. The labor pool will be set up in an area away from the area requiring evacuation. Examples include Adult Day Care, Long Term Care Dining Room, Human Resources, Cafeteria, etc.

c. The mechanism for evacuation will be determined immediately – typically the horizontal (to another wing or section of same floor)/vertical (up or down) evacuation of residents from the area of fire to another designated and defined smoke compartment is best.

d. Evacuation should occur in phases as stated below:

i. Phase one bring the resident/residents to the closest safe smoke compartment.

ii. Phase two brings the resident/residents to the exterior of the building or other designated holding areas.

iii. In conjunction with these two phases separate staff should be assigned to each phase to hasten the evacuation process.

e. Additional staff should be assigned to locate and secure equipment needed by each resident as they are evacuated. This includes oxygen, wheelchairs, gurneys, etc.

f. Oxygen System:

1. The main oxygen shutoff valve for Avera Marshall Regional Medical is located outdoors at the oxygen supply tank (near HR entrance), and also in the oxygen storage room by the loading dock receiving area.

2. It is the responsibility of the Chief Executive Officer to order this valve to be shut off if he/she deems it necessary. In the absence of the Chief Executive Officer, his/her designee or the Director of Environmental Services will assume this responsibility.
3. All other oxygen shutoffs will be the responsibility of the unit in which they are located. This is done based on the knowledge of the oxygen utilization, availability of portable oxygen supply and the location of the fire.
4. The decision to shut off the oxygen will be made by the Director of Environmental Services or his/her designee in conjunction with the fire department, Incident Commander, and the Director of Respiratory Therapy.

DO NOT SHUT OFF OXYGEN VALVES WITHOUT BEING TOLD TO DO SO!!!

WHEN FIRE ALARM SOUNDS:

A. **FOR ALL EMPLOYEES:**

1.

RACE System:	Fire in immediate area! (Each action, each person-vital!)
R=Rescue:	Immediate action may be needed to save a life-and CLOSE THAT DOOR, yet do not delay the alarm
A=Alarm:	Alert help and pull fire alarm
C=Confine:	Close doors and windows, shut off fans to prevent smoke spread and cut off air supply to the fire
E=Evacuate:	The LTC is protected by automatic fire sprinklers, so fight the fire **only if:** ▪ The fire has already been reported ▪ It is small, contained and in its beginning state. Remember P.A.S.S: Pull, Aim, ▪ Squeeze, and Sweep to use the fire extinguisher ▪ The exit is clear and you can fight the fire with your back to the exit ▪ Never go back with another extinguisher
P=Pull	Pull the pin between the handles
A=Aim	Aim at the base of the fire
S=Squeeze	Squeeze the handles together
S=Sweep	Sweep side to side to evenly coat entire area of the fire

2. Turn on all lights in corridors.
3. Clear hallways of any equipment.
4. Know extinguisher locations in your area.
5. Keep all stairways clear and exits unlocked.
6. DO NOT USE ELEVATORS.
    a. LTC First Floor Charge Nurse: Lock open to First Floor Nursing Home.

b. Maintenance Personnel: Lock open to Ground Floor Old Hospital.

7. Request visitors to remain where they are.
8. If an actual fire should occur in your department, the department staff should go to an alternate meeting place.
9. Await further instructions.
10. **ONLY** Environmental Services/Maintenance Dept. will "reset" the fire alarm panel. The department staff may ONLY silence an alarm IF AND ONLY IF, they have proven to the best of their ability and knowledge that no fire does exist.

NOTE: Multiple steps can be performed at he same time by assisting staff.

B. **FOR ALL DIRECT PATIENT CARE PROVIDERS:**
(Long Term Care and Adult Day Care)

1. After implementation of the above 1-9 "FOR ALL EMPLOYEES"
2. Develop evacuation plan for patient case load to include extra help that may be needed to implement plan. The plan must include:
   a. an accurate list of patients,
   b. room numbers,
   c. and how to transfer.
   d. plan for patients requiring respiratory support.
3. Identify rooms with oxygen and suction or electrical appliances and be prepared to disconnect if ordered by the fire department or Environmental Services.

RELATED P&P(S):

Fire Emergency/Code Red Response Policy, Fire alarm Checklist

This policy was developed as a guide for the delivery of health services and is not intended to define the standard of care. This policy should be used as a guide for the delivery of service, although hospital personnel may deviate from this guide to provide appropriate individualized care and treatment for each patient.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Sharon Williams: VP of Finance and Info Technology	02/2017
Kevin Schroeder: Environmental Services Director	02/2017
Dave Skorczewski: Manager	01/2017

Avera Marshall Regional Medical Center

Effective:	*02/2017*
Approved:	*02/2017*
Last Revised:	*02/2017*
Expiration:	*02/2018*
Owner:	*Dave Skorczewski: Manager*
Policy Area:	*Environmental Services (Maintenance,Hskg,Laundry)*
Applicability:	*Avera Marshall Regional Hospital*

Portable Space Heaters

POLICY

Portable Space Heaters

PURPOSE

To control where space heaters are and are not allowed, what features the space heater must have in locations where allowed, and protocol to follow before a space heater is used.

SCOPE

Avera Marshall

PROCEDURE

1. Portable Space Heaters are not allowed in patient care areas or patient/resident sleeping rooms.
2. Portable Space Heaters shall be allowed in non patient care areas provided:
    a. They are UL Listed
    b. They have an automatic shut off if tipped over
    c. They have high limit control that does not exceed 212 degrees
3. All Portable Space Heaters shall be checked by Maintenance before use.
    a. Maintenance will mark Space Heaters to confirm they were inspected

REFERENCE(S)

RELATED P&P(S)

COLLABORATOR(S)

This policy was developed as a guide for the delivery of health services and is not intended to define the standard of care. This policy should be used as a guide for the delivery of service, although hospital personnel may deviate from this guide to provide appropriate individualized care and treatment for each patient.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Sharon Williams: VP of Finance and Info Technology	02/2017
Kevin Schroeder: Environmental Services Director	02/2017

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
February 13, 2017

Ms. Doris Derynck, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5228027

Dear Ms. Derynck:

The above facility was surveyed on January 23, 2017 through January 27, 2017 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 contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00343	A. BUILDING: _____ B. WING _____	01/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 23 - 27th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA)committee identified, evaluated and developed a plan to address concerns with regard to protocols for use of eLTC (a telemedicine service available in the facility) and face to face visits being conducted for emergent acute changes in condition. This deficient practice had the potential to affect all 72 residents in the facility. Findings include:	2 255	Corrected	3/31/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTE	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 255	Continued From page 3 Refer to F309 - Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. This resulted in immediate jeopardy for R66, who experienced actual harm due to delayed treatment for an esophageal obstruction resulting in discomfort, esophageal irritation and risk of aspiration pneumonia/airway compromise as well as actual harm for R116, who had a history of cardiac disease and experienced delayed treatment for severe chest pain. A graph entitled eCARE Senior Care - Avera Morningside Heights Care Center for the dates of 5/2016 through 12/2016 showed a total for this six month period of 37 urgent care video encounters, with a large percentage of telephone and video encounters occurring between the hours of 9:00 a.m. and 3:00 p.m. During interview on 1/25/17, at 11:55 a.m. the medical director (MD)-A for Morningside Care center, stated the goal of the eLTC program was for residents to see a provider timely. eLTC providers were available via telephone, or camera, and could order labs, tests, medications, intravenous lines and x-rays. MD-A explained the facility had a grant and were trying to utilize the service to support immediate access to the doctor. MD-A revealed the service was not appropriate if there was an acute change in care, or the resident had an emergency; with airway obstruction, breathing difficulty or cardiac arrest. MDS explained there were protocols, pathways on the nursing units for the nurse to follow, and stated that "a lot of the situations are	2 255		

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2 255	Continued From page 4	2 255		

non-emergent." When presented with an example of a patient exhibiting signs of a heart attack such as chest pain rated at 8 out of 10, escalating within the hour to 10/10, who was given Maalox for indigestion, and Zofran for nausea, one dose of Tylenol for pain, he responded that he would get the quickest person there, "If the person indicated they wanted to go to the emergency room (ER), then it would be appropriate to send them to the ER". MD-A further stated the doctor must do a face to face and he "believed" the requirement was from CMS, but was not certain. In this situation he confirmed he was disappointed that R116 had not been administered a stronger medication for pain. In addition, MD-A confirmed he was present in the facility three days/week and attended the QAA meetings. MD-A stated improper use of the eLTC system had not been reviewed at the QAA meetings and wished staff would call him more so he could be aware of what medications the eLTC providers were starting on his residents.

During interview on 1/25/2017, at 3:21 p.m. the administrator (who was identified as the facility's primary QA committee contact) stated for emergent situations the resident should go directly to the ER prior to a face to face assessment, however did not feel R66 or R116 experienced emergent health conditions The administrator stated use of the eLTC system was reviewed upon initial orientation and there had been training in 8/2016 on new additions to the program requirements that had been added. There had not been a QA review specifically with regard to whether the system was being used appropriately for non-emergent situations.

During interview on 1/27/17, at 11:23 a.m. the director of nursing (DON) stated sources of

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2 255	Continued From page 5	2 255		

quality improvement ideas included previous survey citations, behavioral management issues, antipsychotic medication reduction recommendations and incident reports. Physician services had been a topic of discussion within the last year, however concerns with eLTC monitoring being used for conditions that might be emergent vs. non-emergent had not. The facility had implemented the eLTC as a method to reduce acute care transfers and repeat trips to the emergency room. The administrator was also present during this interview, and stated she did not feel anything had been done wrong with regard to R66 and her incident of a food bolus obstruction on 6/17/16. Although R66 had not been taken to the emergency department (ED) as directed by her primary physician, the concern had not been addressed via the QA committee, rather MD-A had done a chart review. The administrator further stated if R66 had not been breathing there would have been an event analysis done.

The facility policy entitled Avera Morningside Heights Care Center Quality Assurance and Performance Improvement (QAPI) Committee Design and Scope or Service, last revised 4/15 indicated the program would be ongoing and comprehensive, and address resident care transitions, aiming for safety and high quality while emphasizing autonomy and choice in daily life for residents. The policy indicated the Vice President of Resident care Services will be accountable for the QAPI program.

The facility policy entitled Avera Morningside Heights Care Center QAPI Committee Design and Scope or Service, last revised 4/15 indicated the LTC (long-term care) will have a quality committee. The committee will identify quality

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2 255	Continued From page 6 deficiencies and develop and implement plans of action to correct these deficiencies. The LTC Quality Committee will report to the Quality Committee of the Board. A section entitled Feedback, Data Systems and Monitoring indicated the committee will develop systems to monitor care and services, obtaining data for a variety of sources. Data will be obtained from staff, patients, families and others as appropriate, performance indicators, survey findings, adverse events and other sources as appropriate. SUGGESTED METHOD OF CORRECTION: The facility could revise polices and procedures related to quality assurance and performance improvement with relation to monitoring of emergent care episodes for appropriateness of nursing care and educate staff on these changes. The administrator or designee could audit facility compliance periodically and report to the QAPI committee for further recommendations for facility practice and ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 565	Corrected	3/31/17

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2 565	Continued From page 7 review the facility failed to follow the plan of care for grooming services related to shaving for 1 of 3 residents (R54) reviewed for activities of daily living (ADL's), and failed to ensure a splint was applied to prevent further development of contractures for 1 of 1 resident (R45) reviewed for range of motion. Findings include: On 1/23/17, at 4:22 p.m. R54 was observed seated in recliner in her room. R54 had long unshaven facial near her chin along the jawline on the right side of her face. The hairs were approximated 1/4-1/2 inch in length. The facial hair continued to be present all days of the survey from 1/23/17 through 1/27/17. The care plan revised 1/7/17, for R54 identified a personal care activity of daily living (ADL) goal as noted: It is very important to my mental health that I look well dressed/groomed daily. Interventions included requiring assist of staff for all grooming needs. R54's annual Minimum Data Set (MDS) assessment dated 1/4/17, included a Brief Interview for Mental Status (BIMS) score of 6/15, indicating severe cognitive impairment, and required extensive assistance with personal hygiene. R54's diagnoses included hemiplegia (paralysis on one side of the body) following CVA (cerebrovascular accident/stroke) affecting the right dominant side. When interviewed on 1/26/17, at 2:37 p.m. nursing assistant (NA)-A stated residents need to have their own shavers if wanting to be shaved. NA-A confirmed R54 did not have her own shaver nor had asked to be shaved.	2 565		

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2 565	Continued From page 8 When interviewed on 1/27/17, at 11:02 a.m. NA-A confirmed R54 had long unshaven facial hair mainly on the right side of face, explaining she was aware of the facial hair and questioned R54 approximately 6 months ago whether she desired to be shaved; however, R54 declined. NA-A also stated R54 did not a personal shaver and if she desired to have one, the family would need to purchase a shaver. NA-A verified that R54 preferred to look nice (requested to wear a necklace daily) and had a hair appointment every Monday after her bath. Upon entering R54's room with the surveyor present, NA-A asked R54 whether she preferred to have her facial hair removed if a shaver was purchased for her use. R54 responded, "Yes" and nodded her head up and down. After leaving the room, NA-A approached administrative assistant (AA)-A at the front desk to inform AA-A of R54's need for a personal shaver. When questioned who was responsible for acquiring the shaver, AA-A stated R54's family would have to purchase unless approval was given to use funds from R54's personal funds account for staff to purchase a shaver. When interviewed on 1/27/17, at 11:27 a.m. clinical manager (CM)-B verified residents were required to have their own razor. CM-B stated in the past the facility had community shavers available for resident use but they were not always thoroughly cleaned. Due to the risk of infection if not thoroughly cleaned, residents were required to purchase their own personal shavers. CM-B also confirmed there were no extra shavers available for resident use at this time. CM-B verified the facility was responsible to meet R54's grooming needs per the plan of care.	2 565		

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2 565	Continued From page 9 When interviewed on 1/27/17, at 11:50 a.m. AA-A confirmed the beauty shop did have a shaver available for resident use when they did not have a personal shaver available. R45's care plan, last revised 1/16/17, identified R45 wore a hand splint in right hand/arm 6-8 hours per day and a carrot splint at all times in left hand. The care plan further directed staff to see therapy directions in R45's room for splints/braces. R45's current undated splint order stated: right hand forearm splint/brace on for 6-8 hours per day....on 6:00 a.m. off at 2:00 p.m. Review of R45's quarterly Minimum Data Set (MDS) assessment dated 1/11/17, identified R45 as comatose with a diagnosis of traumatic brain injury (TBI). It further identified R45 as having impairment on both sides of upper extremities with functional limitation in range of motion. On 1/24/17, at 9:32 a.m. R45 was observed lying in bed with a carrot splint in place to left hand. No splint was on right hand at this time. Nursing assistant (NA)-B stated R45 only wore a carrot splint to his left hand, and did not wear or utilize any other splint devices for right hand. On 1/24/17, at 2:06 p.m., licensed practical nurse (LPN)-A was observed to apply a splint to R45's right hand. LPN-A stated R45 was suppose to have splint on and NA-B must have forgot to put it on R45 earlier, indicating it was to be applied with morning cares by the NA. During interview on 1/24/17, at 2:07 p.m. NA-E and NA-D both stated they were only aware of R45 wearing a carrot splint to left hand and not aware of any other devices or splints for right hand.	2 565		

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2 565	Continued From page 10 On 1/26/17, at 10:12 a.m. ROM exercises were completed to both upper extremities by NA-C and NA-D with carrot splint placed to left hand; however, no splint was applied to R45's right hand following the ROM. On 1/27/17, at 8:07 a.m. R45 was laying in bed dressed and groomed, no splint to right hand. At 9:21 a.m. NA-G verified R45 had carrot splint in place on left hand, and stated no other splint is worn by resident. At 9:27 a.m. NA-F also indicated R45 did not wear a right hand splint. During interview on 1/27/17, at 10:22 a.m. LPN-C verified R45 did not have a right hand splint applied as ordered and that splint instructions had not been posted in the room as directed on the plan of care. During interview on 1/27/17, at 10:23 a.m. the director of nursing (DON) confirmed she expected staff to follow the plan of care and verified R45 was to have a right hand splint on 6-8 hours per day as ordered. SUGGESTED METHOD OF CORRECTION: The administrator or designee could audit resident cares for compliance with the care plan. Findings of the audits could be reported to the QAPI committee for ongoing compliance monitoring and further policy change recommendations as necessary. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		3/31/17

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2 830	Continued From page 11 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. Findings include: R66's diagnoses identified on the physician orders signed 4/25/16, included: esophageal stricture, chronic obstructive pulmonary disease (COPD), asthma, dysphonia, dysphagia, gastroesophageal reflux disease (GERD) and dementia. R66's annual Minimum Data Set (MDS) assessment dated 8/23/16, identified a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. The MDS also indicated that R66 fed herself independently, had a swallowing disorder, a	2 830	Corrected	

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2 830	Continued From page 12 mechanically altered diet, and exhibited coughing or choking during meals or when swallowing medications. Review of a Care Area Assessment (CAA) dated 8/23/16, related to nutritional status, revealed R66 had swallowing problems and required a special diet or altered consistency. The CAA indicated R66 had experienced a choking episode requiring transfer to the Emergency room (ER). R66's care plan Updated: 8/18/15 included, "Self-Feeding: I am able to feed myself with staff setup." R66's care plan last revised on 1/8/17 and authored by registered nurse (RN)-F, identified "Diet: NDD3 with ground meat and thin liquids" Also included "My diet was changed to a dysphagia diet and my meat is ground because I had an instance of choking on a piece of chicken in the dining room. I have had problems with my esophagus in the past and have had it dilated before. It is safer tor me to have my meats ground up to not eat real chunky foods. I prefer to have small portions at meals & like to be offered snacks between meals ... Staff and nurses should watch for symptoms increasing related to my esophageal stricture such as coughing at mealtimes, more difficulty swallowing, so they can notify my Dr. and SLP [speech language pathologist] per Dr. order." According to the record, speech language pathologist (SLP) services had been initiated on 12/30/16. On 1/24/17 the speech language pathologist (SLP) documented, "the resident is currently receiving speech therapy to strengthen voice and to evaluate a report from staff of increased coughing during eating." During observation on 1/24/17 at 2:25 p.m., R66	2 830		

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2 830	Continued From page 13 was having a speech therapy session in her room. At that time, the SLP acknowledged R66 was working on voice strengthening. R66 was observed to be actively participating in the session. During an interview with R66 on 1/26/17 at 12:10 p.m., having had walked out to the dining room with assistance, and stated it felt good to walk. In addition, R66 stated she was having no pain or discomfort at this time. On 1/26/17 at 12:37 p.m., R66 was observed to have eaten her entire meal and when finishing the liquids R66 coughed twice. A preoperative history and physical document, authored by MD (medical doctor)-B, dated 6/17/16 at 3:30 p.m. included the following information in regards to R66 choking on a piece of chicken and needing urgent medical treatment: "HISTORY OF PRESENT ILLNESS: The patient has a previously known peptic acid stricture. Her last EGD, (Esophagogastroduodenoscopy, a procedure during which a small flexible endoscope is introduced through the mouth and advanced through the pharynx, esophagus, stomach, and/or duodenum), and dilatation was in April of last year (2015) and she has been doing exceedingly well since then. Today at lunch she took her first bite of her chicken sandwich and it apparently got stuck. The staff at the nursing home tried to get her to take sips of water, tried to cough, they even tried to get her to regurgitate the pieces of chicken up but that all did not work. They contacted me and I asked them to send the patient to the emergency room. For reasons that I still do not quite understand the staff did not bring her to the emergency room as I	2 830		

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2 830	Continued From page 14 requested, as they stated "she needed to have a face-to-face visit first". I explained to the nurse that this is a medical emergency and that she should go to the emergency room directly and I did call [MD-C] and he was waiting for her in the ER to come. I was just notified shortly ago that they were still waiting for me to come to the nursing home. I then brought the patient over here ...with her son, [FM-1] present. The patient still has some chicken stuck in her throat. She is able to speak but she has not been able to swallow and has been regurgitating into any emesis bag off and on her spit and secretions. She does not have any pain except she states that "my chest feels full"... PAST SURGICAL HISTORY: She has had multiple EGDs, as well as dilatations...IMPRESSION: 1. Acute impaction of chicken following lunch today...PLAN: Urgent EGD to remove the foreign body. More than likely we will probably have to stretch or dilate her at a later date in the near future, probably within 1-2 weeks. This is an emergent EGD." The Esophagogastroduodenoscopy Procedure Report dated 6/17/16, included: "Indications: Dysphagia in response to solids, causing acute impaction...The gastroscope was passed with great difficulty through the mouth under direct visualization and advanced to the second portion of the duodenum. The scope was withdrawn and the mucosa was carefully examined...Findings: Esophagus: A large quantity of food was found in the middle third of the the esophagus, 30 centimeters (cm) from the entry site. The food was removed with a basket, with success. Stenosis was found to be causing a moderate obstruction in the middle third of the esophagus, 34 cm from the entry site. The obstruction was traversed (laying across). Moderately erythematous (redness of skin secondary to	2 830		

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2 830	Continued From page 15 injury, infection) mucosa was found in the middle third of the esophagus..." Journal of Gastroenterology & Hepatology, The independent Peer-Reviewed Journal, Gastroenterol Hpatol (NY) 2007 Feb; 3(2): 85-86 includes the following definition: The typical presentation of a patient experiencing a food bolus impaction includes a food bolus impactions are acute events that, for the most part, are immediately recognized by the patient. Most food bolus impactions resolve without intervention, either by moving forward to the stomach or by the patient regurgitating the ingested contents. When symptoms of obstruction persist and/or are accompanied by substantial chest discomfort, patients will seek medical attention. Patients primarily experience a sensation of squeezing in the chest, which can be frightening as it is difficult to discriminate from heart attack pain. However, food bolus impaction is additionally associated with sialorrhea or excessive salivation, which accompanies esophageal obstruction. Patients are also unable to eat or drink anything further when experiencing an impaction. It is important to differentiate impaction from choking. Patients with food bolus impaction do not have any interruption of breathing. They can talk and they can cough, whereas a person who is truly choking is unable to do any of these things. Some of the classic presentations of food bolus impaction are " the steakhouse syndrome " or the " backyard barbeque syndrome. " Not surprisingly, impactions occur more often when patients are eating meat and generally when they	2 830		

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2 830	Continued From page 16 do not chew their food sufficiently. Contributing conditions could be poor dentation, illfitting dentures, the use of alcohol, or a predisposition to eat too quickly. The most commonly impacted foods are beef, chicken, pork, and al dente-cooked vegetables. Review of the nursing progress notes identified as List Resdent (sic) Notes from 6/17/16 to 6/26/16 revealed the following documentation: On 6/17/16 as having occurred at 1230 (12:30 p.m.) but recorded at 2000 (8:00 p.m.) 6/18/16, authored by registered nurse (RN)-A: "Staff reported to RN that resident had been coughing at lunch time and had a emesis of liquids served at mealtime and bits of food. Upon entering room, this nurse found resident sitting in wheelchair holding an emesis bag with son by her side. Resident complained of pain and pointed to upper abdomen area. No complaints of difficulty breathing. Observed intermittent coughing and spitting up of clear secretions. Encouraged resident to cough and take sips of water to try to dislodge food stuck in esophagus without success. Contacted eLTC (a technology based system for medical provider evaluation) to ask for further advice. Spoke with MD [a first name was then documented with a ? behind the name] who recommended having resident swallow some crackers or other sot foods and wait and see if obstruction cleared spontaneously, otherwise send her to the ED (emergency department) if it hadn't cleared by supper time. At this point, son was wanting her to be seen by someone else since these attempts had been unsuccessful. On call physician, Dr [full name, MD-B] was updated about the situation and wanted her to be sent to the ED for further evaluation but unable to see resident prior to an ED transfer. MD-B came to	2 830		

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2 830	Continued From page 17 see resident and take her to ED at around 1520 (3:20 p.m.)." An addendum had also been documented by RN-A at 12:44 p.m. on 6/19/16 related to 6/17/16 incident, "Resident returned to nursing home around 1800 (6:00 p.m.) with family. New orders for diet change and to contact on call doctor if temperature increases to 101. Will monitor for signs of aspiration per orders. Vitals normal range. Resident comfortable and wanted to try a little mashed potatoes and soft vegetables for supper." A note recorded by RN-C on 6/18/16 at 7:44 a.m., for an occurrence from 6/17/16 at 2200 (10:00 p.m.) included: "Resident says she has slight sore throat from having a piece of food caught in her throat and brought to ER to have it removed. She swallowed water well gave medication whole without trouble. T (temperature) 98.6, P (pulse) 64, BP (blood pressure) 110/63, O2 sat (oxygen saturation) 94%, R (respirations) 20." 6/19/16 at 6:00 p.m., RN-A documented, "Resident continues to be free of pain and able to eat regular meals throughout the rest of the weekend with no difficulty. Vitals normal range throughout weekend after return from procedure. Lungs clear all fields. Will continue to monitor for signs of aspiration." 6/28/16 at 10:07 a.m., licensed practical nurse (LPN)-D documented, "Resident brought back from same day surgery post endoscopy with dilatation by her son [FM-1], resident is eating breakfast at this time, Temp 97.2, pulse 71, B/P 174/77. Denies any pain. Done eating states, "I feel like I have to burp." MD-B was interviewed on 1/24/17 at 4:08 p.m., regarding the incident R66 had when food	2 830		

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2 830	Continued From page 18 became lodged in her esophagus 6/17/16 during the noon meal. MD-B said he was the medical doctor on call that day and was working at the local clinic located 8 blocks from the nursing home. MD-B said that RN-A had called him form the nursing home to report that R66 had choked on chicken, and had not been able to swallow some of the meat. MD-B stated he had given RN-A an order to send R66 to the ER. MD-B stated he had proceeded to call the on call doctor for the ER, a surgical circulating nurse, and anesthesia, to be ready when R66 came to the ER and that the nursing home had been advised to bring her immediately to the ER. MD-B went on to explain that R66 needed an emergency surgical procedure in regards to the chicken stuck in her esophagus. MD-B stated when he had finished with the clinic patient he was seeing, he had immediately gone to the hospital's ER to check on the status of R66. MD-B said when he got to the ER, R66 was not in the ER or surgical area. On further investigation, he said he'd been told that R66 was still over at the nursing home. MD-B stated he then had a phone call from RN-B to speak with him. MD-B was informed by RN-A that R66 had to be first seen for a "face to face" visit by a doctor or telemedicine to assess her and determine if she should be seen in the emergency room. MD-B stated when he heard that, he immediately went to the nursing home (connected to the ER) and found R66 holding an emesis bag while in her room. MD-B stated he had spoken to RN-B and informed her R66 "should have been seen in the ER" and that he "did not order telemedicine!" MD-B said RN-B had asked, "What makes this a medical emergency?" MD-B said he had responded to RN-B's question by saying, "When you are drooling, spitting and not able to swallow, you are putting your airway at risk." MD-B then said that	2 830		

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2 830	Continued From page 19	2 830		

this type of medical emergency also includes patient comfort, protection for the airway, and that there was an increased risk for aspiration pneumonia. MD-B said he was in "Awe" that the nursing home had not immediately sent R66 to the ER in accordance with his orders. In regards to requiring a "face to face" and or telemedicine before a resident can be seen in the ER, MD-B said that must be a policy of the nursing home . MD-B said that after talking to the nursing home staff about not having had taken R66 to the ER immediately he had proceeded to take R66 to the ER himself. He stated FM-1 who had been visiting R66 at the time, had gone along to the ER. MD-B stated at the ER they had initiated immediate assessment and preparation for a surgical intervention to remove the lodged chicken meat in the resident's esophagus.

MD-B further stated he had spoken to the director of nursing (DON) by phone following the incident involving R66 not being taken immediately to the ER as he had ordered and wanted this to be looked into by the facility. MD-B said he had been informed by the DON, that the facility was trying to prevent unnecessary visits to the ER. MD-B explained further his understanding from the DON was that the nursing home is using an on call medical system called e-LTC. He stated he'd told the DON, "They [nursing home staff] did not call the telemedicine this time, they called me!" MD-B said the DON had asked him "What makes this a medical emergency?" and that he had explained what constitutes a medical emergency, and why R66 had a medical emergency based on this incident. He said he'd told the DON, "This was an emergent EGD." MD-B further stated that during the phone call with the DON, he had been assured that the facility would look into his concern regarding the

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2 830	Continued From page 20	2 830		

resident's care. However, MD-B said there had been no follow-up received concerning R66's emergency medical concern. MD-B again said without an immediate intervention for R66 to remove the food obstruction, the risk for aspiration increased, and R66 experienced unnecessary discomfort by having to wait to have the food removed. MD-B stated, "Common sense did not prevail in this situation, these impactions are very uncomfortable and there was definitely a delay in treatment." MD-B then stated it was his impression that the directive to have a "face to face" or eLTC did not come from the hospital or the ER, but rather that it was the nursing home's policy.

Family member (FM)-1 was interviewed on 1/25/17 at 4:36 p.m., in regards to R66's medical emergency on 6/17/16. FM-1 stated that he had come to visit his mother after lunch on 6/17/16, and that she "was miserable" and not feeling well. FM-1 said, "I remember the day, it was not handled very good." FM-1 stated a nursing assistant (NA) was in the room with R66 when he'd arrived. He said the NA had been encouraging his mother to cough, but she had food stuck in her throat and kept spitting up. FM-1 again stated, "She was pretty miserable." He then stated staff called the doctor at the Avera e-Care-Long Term Care (eLTC a telemedicine service) and had his mother drink water, eat something soft, and tried to do the Heimlich maneuver. FM-1 said, it seemed like all that she'd eaten came back up, but her throat was still blocked. FM-1 said he was told by RN-A that the doctor had said they were to wait until supper (several hours away) to see if the stuck piece of chicken would resolve by itself. FM-1 said on hearing that, he'd requested RN-A to call another doctor. RN-A called medical doctor (MD)-B, who

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2 830	Continued From page 21 said that he would immediately notify the emergency room (ER) and surgery so they would be prepared for his mother who might require surgical intervention to remove the food. FM-1 confirmed staff had been told to bring R66 over to the ER immediately by MD-B. FM-1 then stated, "we were on our way over to the emergency room when [RN-A] got a phone call that the transfer was off and then said we had to return to the nursing home." FM-1 said when they returned back to his mother's room "RN-A assured me that he would work on it and get it worked out, but it was another 2 hours of watching my mother be miserable until MD-B came in personally and took her to the ER around 5 p.m. FM-1 said when MD-B came in and saw R66 was still in her room "he was not very happy, I think he was more upset then I was." FM-1 added that it had been upsetting to watch his mother suffer stating, "it was mom and I. The NA came into the room two times and the nurse once." FM-1 said when no one seemed to do anything to relieve her discomfort then added, "[MD-B] ended up doing the whole thing himself, and he got the situation handled." FM-1 also stated once she got to the ER, MD-B had his mother go into surgery to have the piece of chicken removed, and that the entire time they'd waited to be seen in the ER, his mom had been miserable and had filled three [emesis] bags with secretions she'd spit up. FM-1 stated he did not blame RN-A because "it was something else in between, he was caught." FM-1 further stated his mother had previously had problems, especially when eating too fast and that her esophagus had been stretched more then once before. FM-1 explained that there was a very narrow passage way, and a softer diet is required. When FM-1 was asked if anyone followed up with him after this episode, FM-1 stated the 'foundation head' person had called	2 830		

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2 830	Continued From page 22 and apologized for the way the situation had been handled. FM-1 said he had been told by the foundation head that the matter would be looked into and had been assured it would not happen again to his mother or any other resident. When FM-1 was asked if he was knowledgeable about the eLTC service, he stated. "I was not aware of the telemedicine Dr. no one has ever talked to me about that." FM-1 expressed relief that MD-B had intervened and stated, "he [MD-B] was concerned about a potential rupture, or that coughing all of that time would cause more damage." Registered nurse (RN)-A was interviewed on 1/25/17 at 8:17 a.m., in regards to the events that happened on 6/17/16 with R66's choking episode. RN-A was asked about the "face to face" eLTC protocol the nursing home utilizes. RN-A said, "On weekends, basically the policy is if the doctor from Avera is here and if they are not available to see the patient [face to face/in person], the nurse can use eLTC system. If the nurse cannot make contact with the doctor [on call], use of the eLTC is always an option for the nurse." RN-A confirmed eLTC had been contacted regarding R66's choking episode on 6/17/16. He verified eLTC doctor had ordered small sips of water, or soft food to try to dislodge the partial obstruction of meat. RN-A stated, when the interventions did not work, he called MD-B, who gave the order to send R66 to the ER. RN-A stated that MD-B was not able to see the resident to do a "face to face" before the transfer, and confirmed it was the facility's policy that if a provider was from the affiliated community medical center (ACMC) versus Avera the MD was supposed to come over to the nursing home to see the resident first and complete a "face to face." RN-A also stated in an emergency situation, such as a stroke or a heart	2 830		

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2 830	Continued From page 23	2 830		

attack, the nurse can use nursing judgement to send the resident directly over to the emergency room. After reviewing the documentation of R66's choking event on 6/17/16, RN-A stated that R66 was coughing up some things, but her airway obstruction did not appear to be "emergent." RN-A further stated R66 "was not turning blue or I would have thought her airway was blocked." RN-A confirmed that MD-B had come over to the facility, and added that the MDs were all aware of the policy regarding the use of eLTC system. RN-A further stated the ACMC providers signed a contract/policy and confirmed that if a family stated they wanted their family member to go to the ER, the nurse must contact the resident's MD to do a "face to face" first. RN-A referred to a care path that is on every care center unit in a binder, to be used to determine if eLTC should be used or not. When asked if the incident on 6/17/16 had been reviewed with him by administration, RN-A stated the incident had been reviewed with him by clinical manager (CM)-A. RN-A continued to say, "I remember that CM-A reminded us to review the current protocols in place, including the care paths." RN-A also said that before the facility had started to use eLTC services, trainers had come in from Sioux Falls, South Dakota to talk with the nursing staff about the use of eLTC.

Medical Director (MD)-A was interviewed on 1/25/17 at 11:55 a.m., in regards to the events that occurred on 6/17/16 with R66's choking episode. MD-A stated that the goal of the eLTC program was for the patient to see a provider timely. The eLTC providers are available via telephone, or camera, and will order labs, tests, medications, intravenous access (IV), x-rays, etc. that can be completed at the nursing home. MD-A explained that the facility has a grant, and are trying to utilize the service to support immediate

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2 830	Continued From page 24 access to the MD, and to prevent unnecessary use of the emergency room (ER) to contain costs. MD-A continued to say that the eLTC service is not appropriate when there is an acute change, such as if the resident had an emergency due to impaired airway, stroke, breathing, and/or cardiac arrest. MD-A explained that there are protocols or pathways the staff are to use and they are located on all the units in the care center for the nurse to follow. MD-A added that "a lot of the situations are non-emergent." MD-A was asked if he participated in the training of care center staff on the eLTC protocols and he said he had not. MD-A said that utilization reports are emailed to him as they occur for his patients. MD-A was asked whether he was aware of R66's medical emergency on 6/17/16, and he said he had reviewed the situation. MD-A stated the event was reviewed previously between administration and himself, and that in his opinion, the situation was handled correctly. MD-A confirmed that the patient was miserable, however stated the resident did not have signs or symptoms of an airway obstruction as evidenced by "can't breathe or speak." MD-A stated if R66 had been sent to the ER nothing could have been done however, sending the patient for an endoscopy was appropriate. MD-A explained that when he worked as the ER MD he would come to the facility and do a face to face with the patient and then send to endoscopy. He stated the eLTC doctor could have given an order to send R66 to the ER and/or hospital. MD-A stated when he'd reviewed the incident regarding this patient, he had not been aware that the eLTC MD had not seen the patient "face to face" to conduct an assessment, since the video equipment had not been turned on. MD-A could not explain why R66 had not been evaluated 'face to face' by eLTC per video as that was the facility's protocol. MD-A	2 830		

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2 830	Continued From page 25 stated there possibly would have been a different response if R66 had been seen by the eLTC MD. In addition, in an email document provided by the facility to surveyors dated 6/29/16 at 2:55 p.m., from MD-A to the nursing home administrator, MD-A had written, "E LTC was called but not on camera so technically no F2F (face to face) consult was made [for R66]." The email was part of the review of the case MD-A had conducted in response to a request by the facility. The director of nursing (DON) was interviewed on 1/24/17 at 5:07 p.m., the DON stated that for acute medical conditions, "if it is an emergency, they are seen emergently in the ER." The DON was unaware of any requirements for a resident to be seen face to face prior to an emergency room transfer and provided a list of residents seen in the emergency department from the long-term care center within the last 12 months. On 1/25/17 at 8:34 a.m., an interview was conducted with the emergency department (ED) manager. The ED manager stated she could not recall the incident for R66 on 6/17/16. However, the ED manager stated the eLTC doctor would tell the nurse at the nursing home when to present a resident to the ER, and that they (eLTC) are trusted to determine when the resident needed to be seen in the ER. The ED manager further verified that a life threatening crisis would require being seen immediately and referenced a CMS (Centers for Medicare/Medicaid Support, a federal regulation division) guideline that is utilized to determine if a resident is seen immediately without first utilizing eLTC. The EDM confirmed that in the instance of a provider giving an order for patient be seen in ER, "the expectation would be for immediate transport."	2 830		

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2 830	Continued From page 26 Registered nurse manager (NM)-A, was interviewed on 1/25/17, at 10:20 a.m., NM-A stated the intent for the eLTC program was for residents to get as much workup done as possible while in the nursing home for non-emergent situations. NM-A stated not being aware of a facility policy that would have required a face to face visit with the MD prior to emergency room transport. NM-A stated the facility had used eLTC for a few years, that events are reviewed periodically, and that nurses are educated/oriented to eLTC processes by other charge nurses. In addition, NM-A recalled that eLTC had been contacted when R66 felt like there was "chicken stuck in throat." NM-A said FM-1 was with R66 and her vital signs had been stable. NM-A also stated, "if a simple intervention here is not going to work, the telemonitor wouldn't work." NM-A confirmed the food bolus put R66 at a higher risk of aspiration. The administrator was interviewed on 1/25/17 at 3:21 p.m., regarding the medical incident with R66 on 6/17/16. The administrator stated if the situation was "emergent" for R66 than she would have gone immediately to the emergency room. The administrator said the decision about whether a medical situation is emergent or non-emergent was determined by the nurse's assessment of the resident. When the surveyor informed him that a face to face had not been completed by eLTC, the administrator confirmed it was an option to talk to eLTC by phone rather than by video. The ADM verified that the expectation for RN-A to ask for a face to face visit when given an order by MD-B would have been the correct protocol. The ADM indicated that if MD-B had refused to do a face to face visit, there is an algorithm for the nurse to follow. The ADM did not know why R66 had not been sent to the	2 830		

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2 830	Continued From page 27 ER when there was an order from to do so by MD-B. When presented with potential issues of aspiration, airway management, and discomfort, the ADM stated she had not been in the facility and had not seen the resident. During a follow up interview with RN-A on 1/26/17 at 8:22 a.m., RN-A stated he remembered having received a call on the way over to the hospital with R66 on 6/17/16. RN-A stated he thought the call had been from the DON, and stated he had been directed not to take R66 to the ER, so he had returned R66 to her room at the facility. On 1/26/17 at 9:24 a.m., the DON confirmed she had worked on 6/17/16 however, denied having called RN-A to stop the transfer of R66 to the hospital. On 1/26/17 at 10:03 a.m., RN-B was interviewed and stated eLTC was used when a resident's provider from Avera was not available. RN-B stated that if the resident used one of the other clinic's physicians, the outside provider ACMC was called first. RN-B said that with either provider group, the doctor did a workup or told the staff to use eLTC, depending on the situation. On 1/26/17 at 10:20 a.m., an interview was conducted with CM-A who verified having worked on 6/17/16. CM-A also denied having called RN-A with directions to return the resident to the facility. CM-A further stated, "there was discussion surrounding the incident after it had occurred and a root cause analysis was completed. The medical director did not feel there was risk of aspiration during that discussion and I did not feel it was my place to second guess that." On 1/27/17 at 11:23 a.m., the DON and	2 830		

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2 830	Continued From page 28	2 830		

administrator stated that RN-A would have been given the eLTC orientation at the time it was implemented, and should have had the basic orientation checklist in his file. The DON again stated she felt the right thing had been done for R66. The administrator then stated that if R66 had been actively choking with distress, RN-A would have taken R66 to the ER. Also the administrator and director of nursing were asked for eLTC process training was requested for RN-A. However, none was provided and none was found in RN-A's personal record when reviewed.

Registered nurse (RN)-A was interviewed on 1/27/17 at 12:33 p.m. regarding eLTC education. RN-A said he had received training regarding a change in the protocol for when to use the eLTC system the prior evening, 1/26/17 after the facility had been informed of the serious concern about R66's 6/17/16 incident.

Review of a document titled Physician Services Agreement (undated) for the medical providers to sign to be designated as the resident's attending physician for each resident included: "Supervising the medical care of [name for resident] means I will: [bullet six] Complete a face to face visit before ordering that a resident be transferred to an Emergency Department or to the hospital (for non-life threatening, non-emergent situations)."

An Avera Marshall Regional Medical Center consent form, was requested for R66 for authorization of eLTC use, the consent form was not provided.

A policy for management of a choking resident, and a policy for the Heimlich maneuver was requested during the survey. A second request

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2 830	Continued From page 29 was made by e-mail to the DON, who responded that the facility did not have a policy specific for a choking resident, or use of the Heimlich maneuver. R116's discharge record was reviewed. A Discharge to NH(nursing home)/AL(assisted living) summary dated 12/21/16, indicated R116 had a previous medical history including: hypertension, atrial fibrillation, pacemaker placement, and arthritis. The discharge summary further identified a primary problem of cardiac amyloidosis (a disease that occurs when a substance known as amyloid builds up in the heart, which causes it to get increasingly stiff and deteriorates the pumping function), hyperkalemia and poor appetite, and indicated R116 was a full code for resuscitation status. R116's admission MDS dated 12/28/16, identified a Brief Interview for Mental Status score of 13 indicating R116 had intact cognition, and had expressed verbal symptoms of pain within the look back. A subsequent discharge tracking MDS, dated 1/2/17 indicated R116 had died in the facility. An Avera Marshall Regional Medical Center consent form, dated 12/22/16 indicated R116's family had authorized use of eLTC services in the absence of her primary physician or his/her designee. An Urgent Care Telehealth Encounter Note dated 12/23/16, indicated R116 had been seen by eLTC due to moderate to severe chest pain which had started around 3:30 p.m. on that date. The note indicated R116 had "acute chest pain, certainly could be unstable angina or NSTEMI (non-st segment elevated myocardial infarction)." In addition, the note indicated staff were to obtain a BNP (lab used to check severity of congestive	2 830		

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2 830	Continued From page 30	2 830		

heart failure), give 40 milligrams of Lasix (a diuretic) intravenously, to stop R116's oral metolazone (another diuretic), and to provide tramadol (a pain reliever) now, and that pending a troponin level (laboratory value of a complex of proteins integral to contraction of the heart muscle that is elevated after a heart attack) could consider Nitroglycerin or morphine for pain control. The note further indicated R116's family was planning on having the resident stay at the nursing home but had decided to transfer her to the emergency room so her case had been discussed with the local emergency room physician. The diagnosis was listed as chest pain, unspecified.

R116's nursing progress notes revealed the following entries:

On 12/23/16 a notation was entered by RN-A 5:24 p.m.: R116 had complained of epigastric/chest area pain this afternoon around 3:30 p.m. She had rated the pain at an 8 on a 10 point scale (10 being the most severe pain). R116 had been administered Maalox (an antacid) and Zofran (a medication for nausea) by RN-A. After 20 minutes, R116 had rated her pain at a 10 out of 10 and an on-call physician was contacted to see R116 but was unable to be reached. As a result, eLTC (a telemedicine service) had been contacted for a workup. An EKG (electrocardiogram), a chest x-ray and review of labs was done. The note indicated pain medication administered and family wished to keep R116 in the nursing home but would consider ED transfer pending lab results and worsening of condition. The note indicated eLTC would be notified as test results came in, that R116 was lying quietly in bed with family at bedside stating the pain was a little better. Will continue to monitor.

R116's EKG results, dated 12/23/16 at 4:54 p.m.

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2 830	Continued From page 31 indicated a ventricular-paced rhythm, no further analysis was obtained due to the fact R116 had a pacemaker. R116's medication administration record (MAR) at the facility revealed R116 had received 30 milliliters of Maalox at 3:40 p.m., a dose of tramadol at 11:03 a.m. and Tylenol tablets, 650 milligrams orally on 12/23/16. The MAR did not reflect any intravenous Lasix administration, nor any further medication being given to R116 to treat chest pain. A subsequent nursing progress note indicated: On 12/23/16 at 7:42 p.m. a notation was documented by licensed practical nurse (LPN)-E: Family requested R116 be transferred to the emergency room at 6:00 p.m. RN notified eLTC doctor. R116 was transferred at 6:10 p.m. R116's ED nursing progress notes indicated she'd arrived in the ER at 6:26 p.m. on 12/23/16 after having only been at the nursing home a couple of days. The notes further revealed that at 7:09 p.m. R116 was found to have a troponin level of 0.159 (indicative of heart muscle damage or increased cardiac risk). The plan of care was discussed with R116 and her family and at 7:49 p.m., R116's family indicated they wanted R116 to be transferred to an outside facility for further treatment. R116's emergency department (ED) visit note dated 12/23/16, authored by medical doctor (MD)-G indicated R116 had started having epigastric pain at 2:00 p.m. after physical therapy, and family and the E care doctor were concerned of a possible MI (myocardial infarction, a term for heart attack) so R116 had been sent to the ED for evaluation and management. R116 complained of pain rated at a 10 out of 10 upon ED admission which was substernal. Modifying factors that were not tried included analgesics, antacids, aspirin, breathing, coughing, eating, exercise,	2 830		

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2 830	Continued From page 32	2 830		

lying down, movement, nitroglycerin, other, oxygen, palpation and rest.
R116's laboratory work revealed that the basic metabolic panel (measuring kidney function and electrolyte function) and a troponin were not collected until 6:26 p.m., after R116 had been transferred to the emergency room.
A follow up nursing home progress note entry indicated the following information:
On 12/24/16 at 4:18 a.m. documentation by LPN-F included: At 8:00 p.m. (on 12/23/16), R116's family came back to her room to get her belongings, stating R116 was being transported to the hospital in Sioux Falls to receive treatment. Family stated this was due to R116 sustaining heart damage and a bed hold was signed per family, as R116 was too upset to make any decisions at this time.
R116's Avera Heart Hospital of South Dakota history and physical dated 12/23/16 at 11:16 p.m., listed a chief complaint of "?" and indicated R116 had been admitted from the ER in Marshall, with concerns of an elevated troponin level and electrolyte imbalances. R116 had received 4 milligrams of morphine to control chest pain along with a heparin bolus (anti-clotting medication) and a nitroglygerin drip prior to transport to South Dakota. Lasix was recommended to help with fluid overload state and to get her potassium level down.
A follow-up visit note at the Avera Heart Hospital indicated R116 was being given additional Lasix to decrease her potassium levels and that discharge was anticipated back to the nursing home as family was considering hospice care.
During interview on 1/24/17 at 5:07 p.m., the nursing home DON was interviewed about when to use eLTC. The DON stated, "If it is an emergency, they are seen emergently in the ER." The DON was unaware of any requirements for a

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2 830	Continued From page 33	2 830		

resident to be seen face to face prior to an emergency room transfer and provided a list of residents seen in the emergency department from long-term care within the last 12 months. The list included R116.

During interview on 1/25/17, at 8:17 a.m. RN-A verified the facility used eLTC services on the weekends and after hours. The facility policy stated that if the resident had an Avera doctor and they were unavailable and needed to be seen, then eLTC would be contacted. RN-A further stated "if you can not get ahold of someone's provider eLTC may also be used." RN-A stated signs of a stroke or a heart attack would warrant nursing judgment to send them directly to the ED. RN-A stated he'd thought the laboratory staff had come over to draw labs on R116 right away, and could not recall when or what type of pain medication R116 had received at the time of her chest pain. RN-A stated he recalled trying to reach an on call doctor regarding R116, however was unable to reach him so used the eLTC doctor. RN-A could not recall informing R116's family of their options at the time for medical care however stated he thought the eLTC doctor had done this. RN-A stated the eLTC program had been in place at Avera Marshall for at least a year or two, and there had been people from Sioux Falls that had come over to educate licensed staff on the equipment and program. In addition, RN-A stated a binder of pathways was located at the nursing desks which was available for staff to reference.

During interview on 1/25/17, at 9:22 a.m. R116's family (F)-2, stated her mother had cardiac amyloidosis and that the options were not clearly explained to her regarding her mother's treatment at the time her mother had started

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2 830	Continued From page 34 having chest pain. F-2 stated the family had signed a consent for eLTC services however, had thought there was no doctor available to take care of their mother at the time she started experiencing chest pain. F2 stated she was unaware her mother could have been sent to the ED right away. F-2 stated she was not sure herself why her mother had not been sent over right away, and that basically as soon as the family was presented with this option they did so. Additionally, F-2 stated her mother had wanted to go to the ED, and had experienced very severe chest discomfort during this time. During interview on 1/25/2017, at 10:03 a.m. RN-B stated eLTC was used when a resident's provider from Avera was not in. If the resident used one of the Affiliated Community Medical Clinic (ACMC) doctors, then the outside provider was called first. Either way the doctor did a workup or told the staff to use eLTC, depending on the situation. There was an eLTC book on the nursing station with a reference link on the computers as well. During interview on 1/25/17, at 10:20 a.m. the RN nurse manager (NM)-A stated the intent of the program was for residents to get as much workup done in the nursing home for non-emergent situations, not symptoms of a heart attack. NM-A indicated serious chest pain would have qualified as an emergent situation warranting transport immediately to the ED. NM-A was not aware of any facility policy that would have required a face to face visit with a doctor prior to emergency room transportation. NM-A was asked what type of clinical conditions/residents she would consider warranting transport to the emergency room vs. using eLTC for and stated "Her [R116]," after reviewing R116's clinical record for 12/23/16.	2 830		

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2 830	Continued From page 35 NM-A reviewed the eLTC pathway book and stated new, acute chest pain which was unrelieved would warrant immediate ED transfer according to the pathway. During interview on 1/25/17, at 11:55 a.m. the medical director (MD-A) stated that the goal of the eLTC program was to see a provider timely. eLTC providers were available via telephone, or camera, and could order labs, tests, medications, intravenous lines and x-rays. MD-A explained that the facility had a grant, and they were trying to utilize the service to support immediate access to the doctor. MD-A revealed that the service was not appropriate if there was an acute change in care, or the resident had an emergency, with airway obstruction, breathing difficulty or cardiac arrest. MDS explained that there were protocols, pathways on the units for the nurse to follow, and stated that "a lot of the situations are nonemergent." When presented with an example of a patient exhibiting signs of a heart attack such as chest pain rated at 8 out of 10, escalating within the hour to 10/10, who was given maalox for indigestion, and Zofran for nausea, one dose of Tylenol for pain, he explained that he would get the quickest person there. "If the person indicated they wanted to go to the emergency room (ER), then it would be appropriate to send them to the ER. MD-A further said that the doctor must do a face to face, and he "believed" the requirement was from CMS, but was not certain. In this situation he confirmed that he was disappointed that the patient (R116) had not been given a stronger medication for pain. MD-A stated there had been hard feelings between the nursing home and one of the other medical providers resulting in some legal issues. During interview on 1/25/17, at 3:21 p.m. the	2 830		

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2 830	Continued From page 36	2 830		

administrator stated she felt eLTC use was appropriate for someone reporting severe chest pain rated a 10 out of 10 and was unable to state what would constitute an emergent versus non-emergent situation in which eLTC would not be used and the resident brought directly to the ED.

During additional interview on 1/25/17, at 1:41 p.m. MD-A (the medical director and also R116's primary physician), stated R116 had an unusual cardiac condition and had been admitted late in the day on 12/21/16 to the facility. R116 had a pacemaker inserted which was not working effectively and was very weak. The medical director stated he had not had time to fully discuss R116's condition with family and had not found out about her episode of chest pain as he had a day off on 12/23/16 until he returned back on duty. The medical director stated the eLTC providers were used after hours for on-call coverage for his residents. The medical director indicated R116's condition was terminal, however wished someone had called him on 12/23/16 and that she "probably should have" gotten pain control from the eLTC physician such as morphine or nitroglycerin on board right away. The medical director stated he did not feel the visit had been very effective in managing R116's symptoms.

A facility policy entitled Physician/Medical Services LTC (long term care), Effective: 11/2011 and Expiration: 11/2017 (page 1 of 4) included:

"F. Complete a face to face visit before ordering a resident to be transferred to an Emergency Department or to a hospital. This requirement is for acute changes in medical condition of a resident. Face to face visit is not required if a

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2 830	Continued From page 37 resident is going to a hospital for a scheduled appointment, and/or a scheduled out patient procedure, or if going to the ED [emergency department] for an emergency, life threatening condition (as specified later in this policy)." The Physician/Medical Services LTC algorithm on page 1. (Undated) included "Change in resident's medical condition, requiring physician intervention (arrow to next box) "Emergency, life threatening medical condition?" (If Yes arrow to next box) "Resident taken to ED [emergency department] for evaluation" (if No arrow to next box) "Resident consent to utilize eLTC present on resident's chart?" (If Yes arrow to next box) "eLTC contacted." SUGGESTED METHOD OF CORRECTION: The facility could review and revise policies related to emergent care, acute changes in resident conditions, physician services and resident transfers and educate staff on the changes. The facility could audit resident records for acute changes in resident condition to monitor for proper nursing and medical follow-up. Results could be reported to the QAPI committee for further recommendations related to ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving	2 850		3/31/17

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2 850	Continued From page 38 of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide facial shaving services to meet the grooming needs for 1 of 3 residents (R54) reviewed for activities of daily living (ADL's). Findings include: On 1/23/17, at 4:22 p.m. R54 was observed seated in recliner in her room. R54 had long unshaven facial near her chin along the jawline on the right side of her face. The hairs were approximated 1/4-1/2 inch in length. The facial hair continued to be present all days of the survey from 1/23/17 through 1/27/17. R54's annual Minimum Data Set (MDS) assessment dated 1/4/17, included a Brief Interview for Mental Status (BIMS) score of 6/15, indicating severe cognitive impairment, and required extensive assistance with personal hygiene. R54's diagnoses included hemiplegia (paralysis on one side of the body) following CVA (cerebrovascular accident/stroke) affecting the right dominant side. The care plan revised 1/7/17, for R54 identified a personal care activity of daily living (ADL) goal as noted: It is very important to my mental health that I look well dressed/groomed daily. Interventions included requiring assist of staff for all grooming needs. When interviewed on 1/26/17, at 2:37 p.m.	2 850	Corrected	

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2 850	Continued From page 39	2 850		

nursing assistant (NA)-A stated residents need to have their own shavers if wanting to be shaved. NA-A confirmed R54 did not have her own shaver nor had asked to be shaved.

When interviewed on 1/27/17, at 11:02 a.m. NA-A confirmed R54 had long unshaven facial hair mainly on the right side of face, explaining she was aware of the facial hair as had questioned R54 approximately 6 months ago whether she desired to be shaved; however, R54 declined. NA-A also stated R54 did not own a personal shaver and if she desired to have one, the family would need to purchase a shaver. NA-A verified that R54 preferred to look nice (requested to wear a necklace daily) and had a hair appointment every Monday after her bath. Upon entering R54's room with the surveyor present, NA-A asked R54 whether she preferred to have her facial hair removed if a shaver was purchased for her use. R54 responded, "Yes" and nodded her head up and down. After leaving the room, NA-A approached administrative assistant (AA)-A at the front desk to inform AA-A of R54's need for a personal shaver. When questioned who was responsible for acquiring the shaver, AA-A stated R54's family would have to purchase it unless approval was given to use funds from R54's personal funds account for staff to purchase a shaver.

When interviewed on 1/27/17, at 11:24 a.m. AA-A confirmed R54's family would be responsible for providing a shaver and/or approval to utilize personal funds for staff to purchase one. AA-A stated in the past the beauty shop used to have a cleanable razor which was used for resident's without a personal shaver. but was unaware whether this was a current option. AA-A stated residents usually were admitted with their own

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2 850	Continued From page 40 personal shavers but she would follow up with the beauty shop. When interviewed on 1/27/17, at 11:27 a.m. clinical manager (CM)-B verified residents were required to have their own razor. CM-B stated in the past the facility had community shavers available for resident use but they were not always thoroughly cleaned. Due to the risk of infection if not thoroughly cleaned, residents were now required to purchase their own personal shavers. CM-B also confirmed there were no extra shavers available for resident use at this time. CM-B verified the facility was responsible to meet R54's grooming needs per the plan of care. When interviewed on 1/27/17, at 11:50 a.m. AA-A confirmed the beauty shop did have a shaver available for residents who did not have their own personal shaver to meet their grooming needs. The policy titled, Resident Quality of Life dated 1/2016, included: Grooming: staff will recognize and obtain resident preference as to how resident wishes to be groomed. Grooming includes the following: Facial hair: how resident likes to be shaved. If a woman, does resident like to have hair removal. SUGGESTED METHOD OF CORRECTION: The administrator or designee could audit resident grooming for compliance with the care plan. The administrator or designee could report results to the QAPI committee for follow up recommendations related to ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		

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2 895	Continued From page 41	2 895		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure a splint was applied to the right hand to prevent further development of contractures (permanent shortening of a muscle or joint preventing normal movement) for 1 of 1 resident (R45) reviewed for range of motion (ROM). Findings include: Review of R45's quarterly Minimum Data Set (MDS) assessment dated 1/11/17, identified R45 as comatose with a diagnosis of traumatic brain injury (TBI). The MDS identified R45 as requiring total assistance for bed mobility, transfers, dressing and personal hygiene. It further identified R45 as having impairment on both sides of upper extremities with functional limitation in range of motion.	2 895	Corrected	3/31/17

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2 895	Continued From page 42 Review of R45's care plan last revised 1/16/17, identified R45 wore a hand splint in right hand/arm 6-8 hours per day and a carrot splint at all times in left hand. The care plan further directed staff to see therapy directions in R45's room for splints/braces. R45's current undated splint order stated: right hand forearm splint/brace on for 6-8 hours per day....on 6:00 a.m. off at 2:00 p.m. On 1/24/17, at 9:32 a.m. R45 was observed lying in bed with a carrot splint in place to left hand. No splint was on right hand at this time. Nursing assistant (NA)-B stated R45 only wore a carrot splint to his left hand, and did not wear or utilize any other splint devices for right hand. On 1/24/17, at 2:06 p.m. licensed practical nurse (LPN)-A was observed to apply a splint to R45's right hand. LPN-A stated R45 was suppose to have the splint on but NA-B must have forgotten to apply earlier with morning cares by the nursing staff. During interview on 1/24/17, at 2:07 p.m. both NA-E and NA-D stated they were only aware of R45 wearing a carrot splint to left hand; not aware of any other devices or splints for right hand. On 1/26/17, at 10:12 a.m. ROM exercises were completed to both upper extremities by NA-C and NA-D with a carrot splint placed to the left hand. However, no splint was applied to R45's right hand following the ROM. On 1/27/17, at 8:07 a.m. R45 was lying in bed dressed and groomed; no splint to right hand. At 9:21 a.m. NA-G verified R45 had a carrot splint in place on left hand but no other splint was worn by	2 895		

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2 895	Continued From page 43 R45. At 9:27 a.m. NA-F also indicated R45 did not wear a right hand splint. When interviewed on 1/27/17, at 10:22 a.m. LPN-C verified R45 did not have a right hand splint applied as ordered and indicated that splint instructions were not posted in R45's room as directed on the plan of care. During interview on 1/27/17, at 10:23 a.m. the director of nursing (DON) confirmed she expected staff to follow the plan of care and verified R45 was to wear a right hand splint on 6-8 hours per day as ordered. During interview on 1/27/17, at 11:33 a.m. the certified occupational therapist assistant (COTA) stated splints are ordered for residents to prevent further contractures and when therapy gives recommendations and schedules for splint use they expect nursing to follow it. A facility policy related to following plan of care was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could audit resident cares related to splints and restorative nursing activities. The administrator or designee could review and revise policies related to range of motion and splints and educate staff related to the changes. The QAPI committee could review the results of audits and make recommendations for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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21995	Continued From page 44	21995		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to implement the Vulnerable Adult Abuse Prevention Plan to ensure immediate reporting of allegations of potential neglect to the State Agency (SA) for 1 of 8 incidents reviewed (R66) who experienced a decline in health status without being transferred to the emergency room immediately as ordered by her primary physician. Findings include: Refer to F309 - Based on observation, interview and document review, the facility failed to ensure timely medical treatment was provided to 2 of 12 residents (R66, R116) reviewed who were transferred from the facility to the emergency room department with acute changes in their condition. This resulted in immediate jeopardy for R66, who experienced actual harm due to delayed treatment for an esophageal obstruction resulting in pain, esophageal irritation and risk of aspiration pneumonia/airway compromise as well as actual harm for R116, who had a history of	21995	Corrected	3/31/17

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21995	Continued From page 45 cardiac disease and experienced delayed treatment for severe chest pain. The facility's Vulnerable Adult Abuse Prevention Plan, last revised 1/2017 indicated: Avera Marshall will not condone abuse of any patient, resident, client and/or participant, by anyone including staff, physicians, volunteers, visitors, or family members. Definition of abuse: the deprivation by an individual, including a care taker, or goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse, sexual abuse, physical abuse and mental abuse including abuse facilitated or enabled through the use of technology. The policy defined neglect as: Failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. All health care employees are mandated reporters. A report is required if there is reason to believe that abuse or neglect has occurred. Immediately means as soon as possible, within minutes of knowledge of the incident. Response to incidents is initiated by conducting a internal investigation of the incident and reporting alleged incidents of neglect to the appropriate state agency. Taking all necessary corrective action. Analyzing the occurrence and determining if any changes are needed in the plan to prevent further occurrences. Keeping an internal log of reports. The policy directed all staff to report any and all incidents of alleged abuse and/or neglect. If a	21995		

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21995	Continued From page 46	21995		

report should be filed with OHFC, the report will be made immediately, upon knowledge of the incident. Review of a decision pathway attached to the Vulnerable Adult Abuse Prevention Plan, identifies that once the administrative personnel are aware of a incident a report is made to the office of health facility complaints (OHFC) immediately. Once a resident care assessment (investigation) is completed, a final report is then submitted to OHFC within 5 days of the incident.

A facility email, dated 6/21/16 indicated the director of nursing (DON) was informed R66 had not been taken to the emergency room immediately as per physician's orders after an esophageal food bolus obstruction by R66's primary physician (MD-B). The DON then conferred with the administrator (A), who subsequently contacted the medical director for a chart review. A report was not immediately made to the state agency (SA) regarding the incident, and an internal investigation into the incident including all relevant staff members was not completed at the time.

When interviewed on 1/27/17, at 8:16 a.m. the director of nursing (DON) stated R66's incident was not reported to the SA since there was not an incident of abuse nor neglect, rather the medical director had completed his own internal review. The DON stated "looking back on it, it might have been reportable, certainly if there would have been a bad outcome for the patient it would have been."

SUGGESTED METHOD OF CORRECTION:
The facility could review and revise policies and procedures related to reporting allegations of resident abuse in the facility, and educate staff on the changes. The administrator or designee could audit incident reports and grievance reports

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21995	Continued From page 47 for timely reporting to the administrator and state agency. Results could be reported to the QAPI committee for ongoing follow up. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21995		