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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 53NP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**
2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **FIRST CARE LIVING CENTER**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/22/2013** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor — 02/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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
11/27/2013
(L33)

DETERMINATION APPROVAL

CCN 24-5512

On September 6, 2013 we completed an OTC Survey at this facility. The most serious deficiency was at a S/S level of F.

Day 70 for this enforcement cycle was November 15, 2013. Compliance with the health and life safety code deficiencies had not yet been verified. The most serious deficiency is at a S/S level of F. As a result of our findings and the 70th day, we recommended the following remedy to the CMS RO for imposition and CMS RO concurred:

Mandatory Denial of Payment for new Medicare and Medicaid Admissions, effective December 6, 2013

If DOPNA goes into effect, the facility would be subject to loss of NATCEP for two years beginning December 5, 2013.

On November 22, 2013, health completed a PCR and on November 21, 2013, life safety completed a PCR and all deficiencies were corrected. As a result of the revisit findings, we recommended the following to the CMS RO for imposition and CMS concurred:

Mandatory Denial of Payment for new Medicare and Medicaid Admissions, effective December 6, 2013, be rescinded.

Since DOPNA didn't go into effect. The facility would not be subject to a loss of NATCEP.

See attached CMS-2567B for the revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 245512 February 6, 2014

Mr. Kevin Dish, Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

Dear Mr. Dish:

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 November 8, 2013 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7272

November 17, 2013

Mr Kevin Dish, Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512023, F5512022

Dear Mr. Dish:

On September 27, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 6, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 8, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on September 6, 2013.

The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 6, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 6, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 6, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, First Care Living Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 6, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the September 5, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, 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 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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 6, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

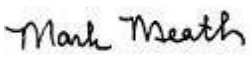
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5512r70dayLtr.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245512	A. Building B. Wing	11/22/2013

Name of Facility	Street Address, City, State, Zip Code
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/08/2013**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **11/08/2013**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/08/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **11/08/2013**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **11/08/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/08/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/08/2013**	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/LB	02/04/2014	28035	11/22/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/6/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245512	A. Building B. Wing 01 - NURSING HOME	11/21/2013

Name of Facility	Street Address, City, State, Zip Code
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0011	**09/20/2013**	ID Prefix Reg. # **NFPA 101** LSC K0025	**09/07/2013**	ID Prefix Reg. # **NFPA 101** LSC K0056	**09/20/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** MM/PS	**Date:** 02/04/2014	**Signature of Surveyor:** 03006	**Date:** 11/21/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 9/5/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Protecting, Maintaining and Improving the Health of Minnesotans

February 4, 2014

Mr. Kevin Dish, Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512023 and F5512022

Dear Mr. Dish:

On November 17, 2013, we informed you that the following enforcement remedy was being imposed:

> • Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 6, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 22, 2013, 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 December 6, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on September 6, 2013, and lack of verification of substantial compliance with the health and Life Safety Code (LSC) deficiencies at the time of our November 17, 2013 notice. The most serious health and LSC deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 22, 2013, the Minnesota Department of Health completed a completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 21, 2013, the Minnesota Department of Public Saety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 6, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 8, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 6, 2013, as of November 8, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 22, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 6, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 6, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 6, 2013, is to be rescinded.

In our letter of November 22, 2013, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 6, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 8, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5512r270dayAllCorrltr.rtf

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 53NP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00461

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245512**
2.STATE VENDOR OR MEDICAID NO.
(L2) **381347904**

3. NAME AND ADDRESS OF FACILITY
(L3) **FIRST CARE LIVING CENTER**
(L4) **900 HILLIGOSS BOULEVARD SOUTHEAST**
(L5) **FOSSTON, MN** (L6) **56542**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/06/2013** (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 **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Anadal, HFE- Nursing Evaluator II 10/28/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 11/27/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN 24-5512

At the time of the standard survey completed September 6, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 3108

September 27, 2013

Mr. Kevin Gish, Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

RE: Project Number S5512023

Dear Mr. Gish:

On September 6, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 16, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 16, 2013 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 6, 2013 (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 March 6, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164	It is the policy of FCLC to provide privacy and confidentiality of residents' personal and clinical records. A. Dietary name cards were corrected 9-5-13 to only state resident's name. B. Education provided to all facility staff regarding Hipaa and Protecting Confidentiality by Mandatory Licensed Staff Meeting October 9 and Mandatory All Staff Meeting October 10, 2013. C. Education provided in an Informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. D. Compliance reported to QAPI meetings quarterly.	All Completion dates are 11/8/13

POC Approved 10/25/13 w/ Addendum (Attached)

D.C 11/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari D. Sick, LNHA	Administrator	10-11-2013

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

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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure private dietary information was not accessible to the public for 23 residents (R50, R19, R13, R29, R26, R33, R68, R59, R37, R38, R56, R34, R66, R15, R27, R55, R11, R42, R3, R1, R51, R43, R20, R67) in the South dining room and for 24 residents (R24, R40, R41, R58, R5, R21, R69, R65, R46, R6, R57, R44, R31, R16, R48, R36, R39, R8, R2, R70, R45, R23, R52) in the North dining room. Findings include: On 9/3/13, at 4:30 p.m. a dining observation was done in the the South dining room. Residents' were observed seated at the tables, with yellow dietary cards on a stand placed in front of each resident. The dietary card included the resident's first and last name and their diet according to the physician's order. This information was visible to anyone entering the dining room. The South dining room dietary cards read: R50-regular diet, texture as tolerated, nectar thick liquids at breakfast, thin liquids rest of day. R19, R13, R33, R15, R43, R51, R3, R42, R11 and R67 all had regular diets.	F 164		

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F 164	Continued From page 2 R29-mechanical soft diet with nectar thick liquids. R26-mechanical soft diet with thin liquids, may have nectar liquids if coughing more than 3 spells a meal. R68 and R59 both had regular low sodium diets. R37 and R27 both had mechanical soft diets with regular liquids. R38-regular diet, small portions. R56-regular low sodium, low fat diet. R34-mechanical soft food, ground meat and regular liquids. R66-regular diet, no added salt. R55-mechanical soft diet with pureed meat. R1-pureed diet with honey thick liquids. R20-low salt diet. On 9/4/13, at 8:57 a.m. a dining observation was done in the the South dining room. The same yellow dietary cards which displayed personal resident information were observed on a stand placed in front of each resident. On 9/5/13, at 7:57 a.m. a dining observation was done in the the South dining room. There same yellow dietary cards were observed on a stand placed in front of each resident. On 9/5/13, at 12:13 p.m. the nutrition services manager (NSM), verified the dietary cards included the residents' diet order. The NSM stated there was a list in the dining room cupboard that identified the residents' diet order. She stated staff could just look inside the cupboard for the information. The NSM stated she had been speaking with registered nurse (RN)-D recently about the dietary cards, and questioned whether it was a privacy issue. The NSM also verified the residents in the North dining room were also using the dietary cards	F 164		

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F 164	Continued From page 3 with their name and diet order listed. The North dining room dietary cards read: R69, R6, R57, R44, R36, R48, R2, R70, R67, R16, R45, and R52 all had regular diets R24-renal diet, low potassium, 1400 ml fluid restriction. R40-ground meat texture, lactose free diet. R41-regular texture with no mixed textures, nectar thick liquids. R58-mechanical soft foods. R5-regular diet with small portions. R21-mechanical soft diet with ground meat. R65-low fat, low sodium diet. R46-low potassium diet. R31-pureed lactose free diet with honey thick liquids. R39-regular 3-4 carbohydrates, no concentrated sweets diet. R8-pureed diet with regular liquids. R23-regular low sodium diet with ground meat. The PRIVACY NOTICE POLICY & PROCEDURE dated 4/03, indicated residents would receive a copy of the Privacy Notice that would explain how their protected health information would be used. The policy further indicated employees, staff and other personnel can access the resident's information.	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	It is the policy of FCLC to promote dignity and respect of residents. A. Charge nurse to ensure that residents R13, R29, R15 receive timely breakfast daily x 2 weeks then randomly thereafter.	

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide timely meals in a manner which promoted dignity for 3 of 3 residents (R13, R29, R15) in the sample who did not receive breakfast. Findings include: R13 did not receive breakfast in a timely dignified manner on the morning of 9/4/13. R13's diagnoses included muscle weakness and shortness of breath. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R13 was alert and oriented, required extensive assistance with activities of daily living and supervision with eating. The plan of care (POC) dated 8/28/13, indicated R13 tolerated a regular diet and was independent with eating after the meal was set up by staff. On 9/4/13, at 9:00 a.m. R13 was observed in his room, seated in a wheelchair. Nursing assistant (NA)-C stated R13 was waiting for his bath. She stated she was not sure if R13 had received breakfast or not. NA-C reported she would look into assisting him with breakfast after providing cares to R13's roommate (R29). - At 9:25 a.m. NA-C completed cares on R29 and opened the curtain between the two residents. R13 stated "I thought you had forgotten about me." NA-C assured the resident and informed R13 she would assist with breakfast and asked what he wanted to eat. - At 9:30 a.m. R13 stated he was not sure if he wanted to eat breakfast. NA-C informed him it	F 241	CONTINUED - F241-E B. Audits to ensure all residents are offered timely meals/snacks and recorded in resident records by Dietary Manager weekly x 4 weeks and randomly thereafter. C. Meals/snacks will be offered in resident's room by the end of designated mealtime if unable to get to dining area, assist by nursing staff per individual POC. D. All staff educated for compliance with meal assistance by Mandatory Licensed Staff meeting October 9 and Mandatory All Staff Meeting October 10, 2013. E. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. F. Compliance reported to QAPI meetings quarterly.	

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F 241	Continued From page 5 would be a long time before lunch and assured him she would bring him toast and coffee. NA-C then wheeled R13's roommate (R29) out of the room. - At 9:40 a.m. NA-C fed R29 breakfast in the dining room. She had not brought R13 toast or coffee as she had promised him. - At 9:45 a.m. R13 was wheeled out of his room towards the tub room. R13 explained to NA-D that he had not receive breakfast. NA-D continued to wheel R13 towards the tub room. - At 9:47 a.m. NA-C confirmed she had not delivered toast and coffee to R13 as promised. She was informed R13 was in the tub and stated R13 will remind her of the breakfast after his bath. - At 10:10 a.m. R13 was returned to his room from the tub room. - At 10:12 a.m. NA-D reported R13 had refused breakfast and he would wait until lunch. She stated she did not know why R13 had not received breakfast. - At 10:20 a.m. R13 stated he usually ate breakfast at the table when he was at home. He became tearful when he stated he did not know why he did not always get breakfast. When asked if he was hungry, R13 stated yes, but it was too late to eat it as it was only an hour until lunch was served. He confirmed the staff had offered to bring him breakfast but they had not returned with anything. R13 stated it was just too late and he was "mad." On 9/4/13, at 11:30 a.m. R13 wheeled himself to the dining room and received lunch. - At 12:06 p.m. R13 stated he was fully satisfied with his lunch, but stated, "I don't know why I didn't get breakfast today."	F 241		

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F 241	Continued From page 6 On 9/4/13, at 12:49 p.m. registered nurse (RN)-A stated she had been informed R13 had not received breakfast this morning. She stated R13 usually ate breakfast in the dining room and stated that was not R13's normal routine. She stated R13 had not been treated in dignified manner regarding his breakfast meal. R29 did not receive breakfast on the morning of 9/6/13. R29's diagnoses included dementia with behavioral disturbances, paranoid states and anxiety. The quarterly MDS dated 5/25/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living including eating. R29's POC dated 7/17/13, directed staff to assist with meals as needed. On 9/6/13, at 8:00 a.m. R29 was observed to be resting in bed with his eyes open. - At 9:00 a.m. R29 was observed sleeping in bed. - At 10:15 a.m. R29 continued to be sleeping in bed. - At 10:30 a.m. R29 remained in bed and had not received breakfast. - At 11:20 a.m. R29 was observed in the dining room during for lunch. R15 did not receive breakfast on the morning of 9/6/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive	F 241		

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F 241	Continued From page 7 impairment and required extensive assistance with activities of daily living. The MDS also indicated R15 was able to feed himself. R15's POC dated 5/22/13, indicated R15 could feed himself after the meal was set up by staff. The POC directed staff to set up his meal and open containers. On 9/5/13, at 8:00 a.m. R15 was served his breakfast meal in the dining room and was observed to eat 100% of the meal independently. On 9/6/13, at 8:00 a.m. R15 was awake and resting in bed. At 9:00 a.m. R15 stated he was hungry. At 10:15 a.m. R15 was observed to have dozed off in his bed. On 9/6/13, at 10:20 a.m. NA-A confirmed R15 and R29 had not received their breakfast. NA-A stated the facility was short two NA's therefore, they were having difficulty keeping up with the needs of the residents. NA-A stated he would assist R15 and R29 with cares. On 9/6/13, at 10:20 a.m. dietary assistant (DA)-A stated she delivered the breakfast cart to the dining rooms at 7:30 a.m. and picked them up at 9:00 a.m. She stated she was not sure when the residents received their breakfast meals. She confirmed she had not been asked to leave a breakfast meal for R15 or R29. On 9/6/13, at 10:23 a.m. the certified dietary manager (CDM) stated the facility was currently serving the residents on a five meal plan. The residents were to be offered a continental breakfast between 7:30 a.m. to 9:00 a.m. lunch would be served at 11:00 a.m. snacks at 2:00	F 241		

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FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 241	Continued From page 8 p.m. supper at 4:30 p.m. and a bedtime snack was to be served at 6:00 p.m. She stated with the five meal plan the residents were allowed to wake up on their own and they could eat when they were ready. She stated by 10:30 a.m. all of the residents' in the facility should have been offered some sort of breakfast. She explained, when the residents were admitted to the facility, she asked them what they like to eat and what was their normal routines which included what time they had eaten breakfast prior to admission. However, she confirmed she did not document the findings in the residents clinical records. The CDM explained if the residents chose to stay in bed after 9:30 a.m. the staff should be offering them something to eat either in the dining room or their rooms. The CDM was not aware R15 and R29 had not received breakfast meals. The CDM reviewed the bedtime snack documentation and reported R15 and R29 had received bedtime snacks on the evening of 9/5/13. On 9/6/13, at 11:00 a.m. R15 and R29 were observed to be sitting in the dining room. R15 stated he had not received his breakfast meal. At 11:20 a.m. R15 and R29 were served lunch. The LTC (long term care) Resident Dietary Program and Dining Experience policy dated 3/6/07 , indicated the residents at the facility were to receive 3 meals and 2 snacks daily.	F 241		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279	It is the policy of FCLC to develop, review, and revise the residents' comprehensive plan of care A. Comprehensive assessment reviewed and care plan revised as appropriate for residents R15 and R38.	

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F 279	Continued From page 9 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care (POC) for 1 of 1 resident (R24) to include the monitoring of a dialysis access port. In addition, the facility failed to develop a POC to include identified interventions for repositioning for 2 of 4 residents (R15, R38) identified at risk for pressure ulcers. Findings include: R24 lacked a comprehensive POC to address the monitoring of a dialysis access port. R24 was diagnosed with diabetes, heart disease and end stage renal failure. The quarterly Minimum Data Set (MDS) dated 6/4/13, indicated R24 had no cognitive deficits and was independent in transfers, ambulation and mobility.	F 279	CONTINUED-F279-E B. Comprehensive assessment reviewed & plan of care revised as appropriate to include monitoring of dialysis access port for resident R24. C. Treatment Assessment Record (TAR) updated to have staff nurses sign off to monitor the dialysis access port daily. TAR instruct staff nurses not to take blood pressure on the same arm as the dialysis access port. TAR instruct staff nurses to monitor for bleeding and interventions in case the access site starts to bleed. D. Comprehensive plan of care reviewed & care plans revised as appropriate to include interventions for repositioning for residents R15, R38 who were identified for risk of pressure ulcers. E. RNCC or her designee will perform repositioning (sitting and lying) audits weekly x 4 weeks for residents R15 and R38 and randomly thereafter. F. RNCC will update care plans quarterly and with any significant changes daily as they occur. G. Random audits for all other residents at risk for pressure ulcers will be completed weekly for 4 weeks then on a random basis by RNCC's or her designee to ensure ongoing compliance with repositioning. H. DON or designee will audit 4 resident records monthly for compliance with care plan updates.	

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F 279	Continued From page 10 R24's POC dated 6/12/13, indicated R24 had dialysis three times a week due to end stage renal disease. The POC indicated R24 received a renal diet and was on 1000 - 1500 fluid restriction and directed staff to monitor weight and oral intake weekly, provide sufficient fluids thru meals and snacks and also to provide education. The POC also indicated no medications or solutions could be given via the dialysis access port unless approved by nephrologist and lab draws should never occur in an extremity containing a dialysis port. The POC directed staff to monitor R24's blood pressure prior to dialysis, however, it failed to direct staff not to take the blood pressure on the same arm the dialysis site was. The POC also failed to identify who was responsible for monitoring the site or how often the access site was to be monitored or what interventions were in place if the access site started to bleed. The facility's North nurse's station had a Nursing Home Plan of Care for Hemodialysis Patients developed and supplied by R24's dialysis provider which directed staff to never to take blood pressure on the extremity that contains a dialysis access. This plan of care also noted the protection of a patients access was critical to their health and well-being on hemodialysis and directed facility staff to perform a daily check of the extremity access. This daily check included feeling for a pulsation in the access, listening for a bruit via stethoscope in the access and assessing for redness, warmth or signs of infection. The plan of care indicated the access dressing and bandages may be removed with 6-8 hours following dialysis and if there was bleeding and if staff were unable to stop the bleeding, directed them to notify the dialysis unit or	F 279	CONTINUED F279-E I. All staff educated for care plan compliance by Mandatory Licensed staff meeting October 9 and Mandatory All Staff Meeting October 10, 2013. J. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. K. Compliance reported to QAPI meetings quarterly.	

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F 279	Continued From page 11 nephrologist for further instructions. On 9/6/13, 8:20 a.m. R24 was observed seated on the bed removing the dressing from the access site. R24 stated she would report any bleeding or signs of infections to the nurse. R24 also stated the nurses had not routinely checked the access site and sometimes would ask her ask about it. On 9/6/13, at 7:03 a.m. registered nurse (RN)-B stated R24's access site was always covered with a dressing when she returned from dialysis and the nurses did not do anything to the site. RN-B stated when the site was new there was something in the electronic medication administration record (e-mar) to do / sign off, but now they don't have to do anything. RN-B stated blood pressures were not to be taken in the arm of the access site and verified the POC lacked interventions related to monitoring the site or directing staff which arm to take blood pressure on. On 9/6/13, at 10:15 a.m. the licensed practical nurse (LPN) and ward clerk verified it was not on the POC but stated it could be added. The LPN stated there used to be an order in the e-mar to check the access site daily but for some reason it was discontinued on 5/17/13. The dialysis policy the facility provided was the Nursing Home Plan of Care for Hemodialysis Patients developed by the dialysis provider. R15's POC dated 8/13/13, indicated R15 was at risk for the development of pressure ulcers and identified interventions such as pressure reducing mattresses on the bed and wheelchair. However,	F 279		

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F 279	Continued From page 12 the POC did not direct the staff as to the frequency to which R15 was to be repositioned. On 9/5/13, a 7:05 a.m. R15 was observed in the main lobby, seated in a wheelchair with a full body mechanical lift sling under him. At 7:50 a.m. R15 was assisted to the dining room for breakfast. At 8:24 a.m. R15 wheeled out of the dining room and down the hallway to the main lobby. While in the lobby R15 was observed to fall asleep while in the wheelchair without receiving assistance. At no time was R15 observed to be able to reposition himself in the wheelchair. At 10:33 a.m. nursing assistant (NA)-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been repositioned since that time. NA-C and NA-A then assisted R15 to bed via a full body mechanical lift. R15's wheelchair was observed to be equipped with a pressure redistribution cushion. R15's skin was observed to be pink and intact free of pressure ulcers. At 10:40 a.m. NA-C confirmed R15 had not received assistance with repositioning between 6:30 am. and 10:33 p.m. a total of 4 hours and 3 minutes. On 9/5/14, at 12:35 p.m. registered nurse (RN)-A stated R15 was to receive assistance with repositioning every two hours and stated the POC should have been revised to direct the staff regarding the repositioning schedule. R38's diagnoses included a history of pressure ulcers (PU), arterial disease and peripheral vascular disease (PVD), a circulatory problem. R38's quarterly MDS indicated she had PU's and was at risk for the further development of PU's	F 279		

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F 279	Continued From page 13 and required two staff extensive assistance for transfers and bed mobility. R38's current POC dated 8/28/13, indicated R38 was at risk for pressure ulcers and directed staff to assist with repositioning and offloading (pressure relief) every hour during awake hours, however, the POC lacked indication of the frequency R38 was to be turned and repositioned while in bed. On 9/5/13, R38 was observed continuously in bed on her back from 7:05 a.m. until 10:15 a.m. At 10:15 a.m. NA-C stated R38 was placed on her back at 7:00 a.m. and verified R38 was to be turned in bed every 2 hours. At this time, R38 was turned to her left side to receive cares. (3 hours and 15 min without repositioning). At 1:02 p.m. RN-A verified R38 was at risk for PU's. RN-A stated R38 was to be repositioned every 2 hours while in bed. RN-A verified the repositioning schedule for R38 while in bed was not addressed on the POC. The Care Planning policy revised on 1/2009, directed staff to develop a comprehensive care plan for each resident.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	It is the policy of FCLC for residents to have a right to participate in care planning. A. Revision of comprehensive plan of care to reflect dental status of R29.	

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F 280	Continued From page 14 changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care (POC) to accurately reflect the oral status / care needs for 1 of 1 resident (R29) reviewed. Findings include R29's POC dated 7/17/13, indicated R29 had upper and lower dentures and directed staff to assist with oral cares twice a day and as needed. On 9/5/13, from 9:00 a.m. to 9:30 a.m. nursing assistants (NA)-A and NA-C were observed to provide R29 total assistance with morning cares. R29's natural teeth were observed to have multiple blackened areas with white matter build up between them. At 9:27 a.m. NA-C offered R29 a drink of water, but at no time was R29 offered	F 280	CONTINUED F280-D B. Resident and family invited and encouraged to participate in quarterly care plan conferences. C. Chart review of all current residents were completed and charts were updated to reflect residents current dental status. D. All staff educated for compliance with individual POC for all residents regarding their dental needs by Mandatory Licensed Staff meeting October 9 and Mandatory All Staff meeting October 10, 2013. E. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. F. RNCC or her designee will audit R29 oral cares weekly x 4 weeks and randomly thereafter. G. Random audits for all other residents will be completed weekly for 4 weeks then on a random basis by RNCC or her designee to ensure ongoing compliance with care plan updates. H. Compliance reported to QAPI meetings quarterly.	

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F 280	Continued From page 15 an opportunity to brush his teeth. On 9/5/13, at 9:40 a.m. NA-C assisted R29 with breakfast in the dining room. At 10:10 a.m. R29 was wheeled to the main lobby to participate in morning activities. At 10:15 a.m. NA-C confirmed R29 had his own teeth and verified oral cares had not been provided nor offered during morning cares. On 9/6/13, at 8:10 a.m. the director of nurses (DON) asked NA-A what type of teeth R29 had. NA-A reported R29 may have a partial, but the majority of his teeth were natural. The DON confirmed R29's POC had not accurately reflected R29's current oral status / needs and stated oral cares should have been completed. The Care Planning policy revised on 1/2009, directed staff to completely review the care plan for each resident quarterly and update (revise) the plans of care when needed.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care (POC) for 1 of 4 residents (R15) who were	F 282	It is the policy of FCLC to follow the residents' plan of care. A. Written warning and counseling was completed on September 9, 2013 with both staff members that were in the room during the cares with resident R15. B. Comprehensive assessments reviewed and care plans revised as appropriate for residents R55, R38 who required assist with repositioning identified as risk for pressure ulcers.	

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F 282	Continued From page 16 observed for perineal care; the facility failed to provide ambulation services according to the POC for 1 of 1 resident (R13) reviewed for ambulation; the facility failed to provide incontinence care according to the POC for 3 of 3 residents (R38, R29, R15) reviewed for incontinence care. In addition, the facility failed to provide repositioning according to the POC for 2 of 5 residents (R38, R55) in the sample identified at risk for pressure ulcers. Findings include: INCONTINENCE CARE: R38 was admitted on 9/12/12, with a pressure ulcer on her ankle and upper back. R38 also had arterial disease and peripheral vascular disease (PVD) a circulatory problem. R38's The current POC dated 7/3/13, directed staff to check R38's incontinent product every 2-3 hours during the day. On 9/5/13, from 7:05 a.m. until 10:09 a.m. R38 was continuously observed asleep on her back, in bed. At 10:09 a.m. nursing assistant (NA)-A and NA-C entered R38's room. Both verified there were assigned to R38's wing (South wing) At 10:15 a.m. NA-C stated R38s brief was changed at 7 a.m. and R38 was incontinent of urine at that time. NA-C stated R38's brief was to be changed every 2 hours. At 10:20 a.m. NA-C changed R38's brief which was observed to be very wet. (3 hours and 20 minutes after the last brief change).	F 282	CONTINUED F282-E C. Comprehensive assessments reviewed and care plans revised as appropriate for residents R15, R29, R38 who required assist with incontinence cares. D. Comprehensive assessment reviewed and care plan revised for resident R13 who requires assist with ambulation. E. All staff educated for compliance regarding following the plan of care for all residents by Mandatory Licensed Staff meeting October 9, 2013 and Mandatory All Staff Meeting October 10, 2013. F. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. G. RNCC or her designee will audit compliance of plan of care for R55, R38, R29, R13, R15 weekly x 4 weeks, then randomly thereafter. H. Random audits for all other residents will be completed weekly x 4 weeks then on a random basis by RNCC's or their designee to ensure ongoing compliance with repositioning, incontinence cares, and ambulation program according to care plan. I. Compliance reported to QAPI meetings quarterly	

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F 282	Continued From page 17 At 1:02 p.m. registered nurse (RN)-A stated R38's incontinent product was to be changed every 2-3 hours during the day. RN-A verified the POC was not followed. REPOSITIONING: On 9/5/13, at 1:02 p.m. RN-A verified R38 was at risk for PU's. RN-A stated R38 was to be offloaded hourly when up in the wheelchair. On 9/6/13, from 8:36 a.m. until 10:53 a.m. R38 was continuously observed seated in her wheelchair At 10:53 a.m. NA-B stated R38 was assisted into the wheelchair at 8:20 a.m. NA-B stated her and NA-A were the primary NAs for R38. NA-B verified R38 had not been repositioned since she was assisted into the wheelchair. NA-B confirmed R38 was to be repositioned every hour when in the wheelchair. At 10:55 a.m. NA-A and NA-B were observed to stand / offload R38. (2 hours and 35 minutes without repositioning). R55 was not repositioned as directed by the POC. R55's POC dated 4/10/13, indicated R55 had a history of pressure ulcers and directed staff to assist R55 with repositioning every two hours and as needed. On 9/5/13, from 7:05 a.m. to 9:50 a.m. R55 was observed seated in her wheelchair without assistance with repositioning. At 9:50 a.m. NA-A and NA-C was observed to assist R55 to bed via	F 282		

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F 282	Continued From page 18 a full body mechanical lift. R55's wheelchair was observed to be equipped with a pressure redistribution cushion. A skin protective dressing was observed to be intact over the left hip. On 9/5/13, at 10:00 a.m. NA-A confirmed R55 had been assisted out of bed at 7:00 a.m. and had not received assistance with repositioning since that time. A total of 2 hours and 50 minutes earlier. On 9/5/13, at 12:40 p.m. RN-A stated R55 was at risk for the development of pressure sores and was to repositioned every two hours as the POC directed Perineal and Incontinence cares: R15 did not receive assistance with perineal or incontinence cares as the POC directed for greater than 4 hours on the morning of 9/5/13. R15's POC dated 8/13/13, indicated R15 required total assistance of 1-2 staff for perineal cares and directed staff to provide incontinence cares every two hours. . On 9/5/13, a 7:05 a.m. R15 was observed seated in a wheelchair. At 7:50 a.m. R15 was assisted to the dining room for breakfast. At 8:24 a.m. R15 wheeled out of the dining room and down the hallway to the main lobby. R15 was observed to fall asleep in the wheelchair while in the main lobby and without receiving assistance. At 10:33 a.m. NA-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been assisted with incontinence cares since that time. NA-C and NA-A then assisted R15 to bed via a full body	F 282		

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F 282	Continued From page 19 mechanical lift. R15 was observed to be wearing an incontinence product which was saturated with urine. NA-A removed the saturated brief and applied a fresh brief. At no time was R15 observed to receive assistance with perineal cares. At 10:40 a.m. NA-C confirmed R15 had not received assistance with incontinence cares between 6:30 am. and 10:33 p.m. a total of 4 hours and 3 minutes. In addition NA-C confirmed R15 had not received perineal cares after having an incontinent episode. On 9/5/14, at 12:35 p.m. RN-A stated R15 was to received incontinence cares every two hours, and perineal cares after each incontinent episode as directed by the POC. Ambulation: R13's POC dated 8/28/13, directed two staff to assist R13 to a standing position and to use a four prong cane to assist R13 to ambulate up to 40 feet or more 2-3 times per week. On 9/4/13, at 4:03 p.m. R13 stated he used to walk all of the time, but had not walked as much because he required assistance with ambulation. Review of Ambulation Roster identified the following information. The week of 6/8/13 - 6/14/13, R13 ambulated five times with distances carrying from 10 feet to 50 feet. The week of 6/15/13 - 6/21/13, R13 ambulated 20 feet two times. The week of 6/22/13- 6/28/13, R13 ambulated 10	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	09/06/2013

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F 282	Continued From page 20 feet on one occasion. The week of 6/29/13- 7/5/13, R13 ambulated 25 feet on one occasion. The week of 7/6/13 - 7/12/13, R13 ambulated 15 feet on one occasion. The week of 7/13/13 - 7/19/13, R13 did not ambulate. The week of 7/20/13 - 7/26/13, R13 did not ambulate. The week of 7/27/13 - 8/3/13, R13 ambulated 35 feet on once occasion. The week of 8/4/13- 8/10/13, R13 ambulated 3 times with distances varying from 10 feet to 100 feet. the week of 8/11/13- 8/17/13, R13 ambulated 13 feet one time. The week of 8/18/13 - 8/24/13, R13 ambulated 100 feet one time. The week of 8/25/13 - 8/31/13, R13 ambulated 3 times with distances varying from 50 feet to 200 feet. The week of 9/1/13- 9/6/13, R13 ambulated 3 times with distance varying from 55 feet to 125 feet. On 9/6/13, at 8:10 a.m. R13 was observed to ambulate with restorative nursing assistant (RNA)-A and NA-C with licensed practical nurse (LPN)-C following with the wheelchair. R13 was able to ambulate 100 feet with assistance. On 9/6/13, at 10:00 a.m. RN-C confirmed R13 had not consistently received assistance to ambulate as the POC directed. Incontinence cares and repositioning: R29 did not receive timely assistance with	F 282		

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F 282	Continued From page 21 incontinence cares and repositioning on the morning of 9/5/13, as directed by the POC. R29's POC dated 7/17/13, directed staff to assist with incontinence cares and repositioning every two hours. On 9/5/13, at 7:10 a.m. R29 was observed in bed on his back. R29 was observed to remain on his back until 9:10 a.m. at which time NA-A and NA-C were observed to provide R29 with morning cares. R29 was observed to be incontinent of bladder with intact skin. On 9/5/13, at 9:40 a.m. NA-C stated R29 had been last assisted with incontinence cares at 6:00 a.m. a total of 3 hours and ten minutes earlier. On 9/5/13, at 1:00 p.m. RN-A stated R29 was to receive assistance with incontinence cares and repositioning every two hours as directed by the POC. The Care Planning policy revised on 1/09, directed staff to follow the plan of care to ensure safety for the resident, staff members and facility.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 311	It is the policy of FCLC to ensure treatment/ services to improve/maintain resident ADL's. A. Review of comprehensive assessment, therapy recommendations, and care plan updated as appropriate for resident R13. B. RNCC or her designee wil audit R13 ambulation program weekly x 4 weeks and randomly thereafter.	

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F 311	Continued From page 22 review, the facility failed to provide ambulation services according to the assessed need for 1 of 1 resident (R13) in the sample. Findings include: R13's diagnoses included muscle weakness, shortness of breath and peripheral vascular disease. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R13 was cognitively intact and required extensive assistance for bed mobility, transfer and ambulation. The Quarterly Review form dated 8/20/13, indicated R13 was able to ambulate with assist of two staff using a gait belt and a four prong cane. The form also indicated R13 had occasionally became anxious when ambulating but with encouragement R13, was able to ambulate. R13's plan of care (POC) dated 8/28/13, directed two staff to assist him to a standing position and to use a four prong cane to assist R13 to ambulate up to 40 feet or more 2-3 times per week. On 9/4/13, at 4:03 p.m. R13 stated he used to walk all of the time, but he had not walked as much now because he required assistance with ambulation. Review of Ambulation Roster identified the following information: The week of 6/8/13 - 6/14/13, R13 ambulated five times with distances varying from 10 feet to 50 feet. The week of 6/15/13 - 6/21/13, R13 ambulated 20 feet two times.	F 311	CONTINUED F311-D C. RNCCs or their designee will audit the restorative aide documentation monthly to ensure ambulation programs of all residents have been completed according to plan of care. D. All staff educated for expectations with compliance with ambulation/restorative program by Mandatory Licensed Staff Meeting October 9 and Mandatory All Staff meeting October 10, 2013. E. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. F. Compliance reported to QAPI meetings quarterly.	

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F 311	Continued From page 23 The week of 6/22/13- 6/28/13, R13 ambulated 10 feet on one occasion. The week of 6/29/13- 7/5/13, R13 ambulated 25 feet on one occasion. The week of 7/6/13 - 7/12/13, R13 ambulated 15 feet on one occasion. The week of 7/13/13 - 7/19/13, R13 did not ambulate. The week of 7/20/13 - 7/26/13, R13 did not ambulate. The week of 7/27/13 - 8/3/13, R13 ambulated 35 feet on once occasion. The week of 8/4/13- 8/10/13, R13 ambulated 3 times with distances varying from 10 feet to 100 feet. The week of 8/11/13- 8/17/13, R13 ambulated 13 feet one time. The week of 8/18/13 - 8/24/13, R13 ambulated 100 feet one time. The week of 8/25/13 - 8/31/13, R13 ambulated 3 times with distances varying from 50 feet to 200 feet. The week of 9/1/13- 9/6/13, R13 ambulated 3 times with distance varying from 55 feet to 125 feet. The Ambulation Roster documented reasons why R13 had not ambulated were "unable," "not available," "refused" or "was able to stand for weight bearing." On 9/6/13, at 8:10 a.m. R13 was observed to ambulate with restorative nursing assistant (RNA)-A and nursing assistant (NA)-C with licensed practical nurse (LPN)-C following with the wheelchair. R13 was able to ambulate 100 feet with assistance. On 9/6/13, at 10:00 a.m. registered nurse (RN)-C	F 311		

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F 311	Continued From page 24 stated R13 had occasionally refused to ambulate, but still had the ability to walk. RN-C stated due to low staffing patterns, the staff did not have the time to complete the ambulation programs. She confirmed R13 had not consistently received assistance to ambulate as directed by the POC. On 9/6/13, at 10:30 a.m. RNA-A stated the restorative programs had not been consistently implemented because of short staffing. She stated if the computer documentation was marked as refused, unavailable, or unable, it may have been due to the resident being physically unable to ambulate, or that the facility did not have a restorative nursing assistant that day. She stated when the documentation was completed, the staff had not indicated any further explanation as to why the resident did not participate in the restorative program. She confirmed R13 had not received consistent implementation of the restorative program. The Walking Program, Direct Care Staff policy revised on 11/2002, directed the staff to provide assistance to ensure the resident maintain the highest level of range of motion and mobility as possible.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312	A. Comprehensive assessment reviewed and care plan revision as appropriate for oral hygiene needs of resident R29. B. Chart review of all current residents completed and charts were updated as appropriate according to individual oral hygiene needs.	

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F 312	Continued From page 25 by: Based on observation, interview and document review, the facility failed to provide assistance with oral cares for 1 of 1 resident (R29) in the sample who was dependent on staff for oral hygiene. In addition, the facility failed to provide perineal care for 1 of 3 residents (R15) reviewed for incontinence care. Findings include: R29 did not receive assistance with oral care on the morning of 9/5/13. R29's diagnoses included dementia with behavioral disturbances, paranoid state and anxiety. The quarterly Minimum Data Set (MDS) dated 5/25/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living. The MDS did not identify any concerns with R29's teeth. Review of the clinical record did not contain any type of assessment related to R29's oral cavity or teeth. R29's plan of care (POC) dated 7/17/13, identified R29 as having upper and lower dentures and directed staff to assist with oral cares twice a day and as needed. On 9/5/13, from 9:00 a.m. to 9:30 a.m. nursing assistants (NA)-A and NA-C were observed to provide R29 total assistance with morning cares. R29's natural teeth were observed with multiple blackened areas with white matter build up between them. At 9:27 a.m. NA-C offered R29 a drink of water, but at no time was R29 offered an	F 312	CONTINUED F312-D C. SSD/TREC monitors / ensures admission & annual dental exams per resident/ family preference and tracks exams in resident's charts. D. Nursing staff weekly oral mucosa/ dental condition checks on bath day. E. Comprehensive assessment reviewed and care plan revision as appropriate for incontinence needs of resident R15. F. RNCC or her designee will audit oral cares weekly x 4 weeks for resident R29 and randomly thereafter. G. RNCC or her designee will audit incontinence cares weekly x 4 weeks and randomly thereafter for resident R15. H. Random audits for all other residents will be completed weekly x 4 weeks then on a random basis by RNCC or her designee to ensure ongoing compliance with oral cares and incontinent cares. I. RNCC will complete dental assessments and bowel and bladder assessments on all residents on admit, quarterly, and with significant changes.	

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F 312	Continued From page 26 opportunity to brush his teeth. On 9/5/13, at 9:40 a.m. NA-C assisted R29 with breakfast in the dining room. At 10:10 a.m. R29 was wheeled to the main lobby to participate in morning activities. At 10:15 a.m. NA-C confirmed R29 had his own teeth and oral cares had not been provided or offered during morning cares. On 9/5/13, at 12:50 p.m. registered nurse (RN)-A verified R29 was to receive assistance with oral cares each morning. She stated at no time when completing the MDS / assessment had she been instructed to physically look into R29's mouth. She stated she was unaware if R29 had dentures or natural teeth. On 9/6/13, at 8:10 a.m. the director of nursing (DON) asked NA-A what type of teeth R29 had. NA-A reported R29 may have a partial, but the majority of his teeth were natural. The DON confirmed R29's POC had not accurately reflected R29's current oral status and verified oral cares should have been completed. A policy regarding oral care was requested but not provided. R15 did not receive assistance with perineal cares after an incontinent episode on 9/5/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive impairment and required extensive assistance with activities of daily living. The MDS also	F 312	CONTINUED F312-D J. All staff educated on oral hygiene compliance and incontinence care by Mandatory Licensed Staff Meeting October 9, and Mandatory All Staff Meeting October 10, 2013. K. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. L. Compliance reported to QAPI quarterly	

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F 312	Continued From page 27 indicated R15 was frequently incontinent of bowel and bladder. The Urinary Incontinence Care Area Assessment (CAA) dated 8/13/13, indicated R15 was frequently incontinent of bowel and bladder and directed staff to assist with incontinence cares every two hours. The B & B H& P (Bowel and Bladder History and Physical) Assessment dated 8/6/13, identified R15 as being incontinent of bowel and bladder and required extensive assistance of two staff to use the toilet. The assessment directed staff to assist R15 with incontinence cares every two hours. R15's POC dated 8/13/13, directed staff to assist with incontinence cares every two hours and required extensive total assistance with pericares after each incontinent episode. On 9/4/13, at 10:33 a.m. NA-C and NA-A assisted R15 to bed via a full body mechanical lift. R15 was observed to be wearing an incontinence product which was observed saturated with urine. NA-A removed the soiled brief and applied a clean brief. At no time did the nursing assistants provide R15 with perineal care. At 10:40 a.m. NA-C confirmed R15 had not received assistance with perineal cares after being incontinent of urine. On 9/5/14, at 12:35 p.m. RN-A stated R15 was to receive perineal cares after each incontinent episode as directed by the POC. The Bladder and Bowel Assessment policy	F 312		

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F 312	Continued From page 28 revised on 11/2006, included an undated manufacturer's guidelines which directed the staff to provide peri-care after removing a soiled incontinent product.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident identified at risk for pressure ulcers (PU) received timely repositioning for 4 of 5 residents (R38, R15, R55 and R29) in the sample identified at risk for pressure ulcers. Findings include: R38 was at risk for pressure ulcers and did not recieve turning and repositioning assistance for three hours and 15 minutes on 9/5/13, and two hours and 35 minutes on 9/6/13. R38 was admitted on 9/12/12, with a PU on her ankle and upper back. R38 also had arterial disease and peripheral vascular disease (PVD, a circulatory problem).	F 314	It is the policy of FCLC to provide treatment/ services to prevent/heal pressure sores. A. Comprehensive assessment reviewed and care plan revision as appropriate for residents R29, R38, R15, R55. B. Weekly skin assessments for all residents completed on bath day by nursing staff and documented in EHR. C. RNCC will review tissue tolerance on admit, quarterly, with any sig change, and repositioning will reflect residents individualized needs. D. RNCC or her designee will audit repositioning weekly x 4 weeks then on a random basis by to ensue ongoing compliance with repositioning for residents R29, R38, R15, R55. E. Random audits for all other residents will be completed weekly x 4 weeks and then on a random basis by RNCC or her designee to ensure ongoing compliance with repositioning according to their individualized plan of care.	

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F 314	Continued From page 29 The Assessment of Pressure Sore Potential dated 6/20/13, indicated R38 was at risk for PU development. The quarterly Minimum Data Set (MDS) dated 6/25/13, indicated R38 was cognitively intact, required two staff extensive assistance for repositioning and had two stage one PU's. The PU Care Area Assessment (CAA) dated 9/5/13, indicated R38 was admitted with PUs. R38's plan of care (POC) dated 8/28/13, indicated R38 was at risk for pressure ulcers and directed staff to assist with repositioning and offloading (presure relief) hourly during awake hours. The POC lacked indication of R38's repositioning needs when in bed. On 9/4/13, at 10:01 a.m. R38 stated she did get tired from sitting in her wheelchair. On 9/5/13, at 7:05 a.m. R38 was observed asleep on her back in bed. R38 was continuously observed in bed, on her back until 8:37 a.m. - At 8:37 a.m. R38 was observed awake and remained on her back in bed. R38 was continuously observed in bed,on her back until 9:47 a.m. - At 9:47 a.m. R38 was awake on her back in bed. R38 stated she was still waiting to get up. R38 asked, "What takes them so long?" R38 was observed continuously on her back until 10:09 a.m. - At 10:09 a.m. nursing assistant (NA)-A and NA-C entered R38's room. - At 10:11 a.m. NA-C stated her and NA-A were the NAs assigned to the South wing. - At 10:15 a.m. NA-C stated R38 was placed on	F 314	CONTINUED F314-E F. All staff educated on the reposition auditing program and compliance with the repositioning programs by Mandatory Licensed staff meeting on October 9 and Mandatory All Staff Meeting October 10th, 2013. G. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. H. Compliance reported to QAPI meetings quarterly.	

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F 314	Continued From page 30 her back at 7:00 a.m. and was to be turned in bed every 2 hours. At this time, R38 was turned to her left side to receive cares. (3 hours and 15 min without repositioning). - At 10:17 a.m. R38 asked NA-A, "Why are you so late?" - At 1:02 p.m. registered nurse (RN)-A stated R38 was identified at risk for PU. RN-A stated R38 was to be offloaded hourly when up in the wheelchair, and every two hours while in the bed. RN-A verified the repositioning schedule for R38 while in bed was not addressed on the care plan. On 9/6/13, at 8:36 a.m. R38 was observed in her wheelchair at the breakfast table. R38 was continuously observed until 9:27 a.m. - At 9:27 a.m. the social service designee brought R38 to her room. - At 9:35 a.m. R38 was observed to remain up in her wheelchair in her room. - At 9:38 a.m. activity aide (AA)-A brought R38 to exercise group in the lobby. R38 was continuously observed until 10:50 a.m. - At 10:50 a.m. R38 stated her bottom was sore from sitting. - At 10:53 a.m. NA-B stated R38 was assisted into the wheelchair at 8:20 a.m. NA-B stated R38 had not been repositioned since she was placed in the wheelchair. NA-B stated R38 was to be repositioned every hour in the wheelchair. - At 10:55 a.m. R38 was observed to be stand with NA-A and NA-B's assistance for repositioning / offloading. (2 hours and 35 minutes without repositioning). - At 11:00 a.m. NA-B stated the lack of repositioning occurred due to understaffing. R15 did not receive assistance with repositioning for greater than four hours on the morning of	F 314		

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FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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 314	Continued From page 31 9/5/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive impairments and required extensive assistance with activities of daily living. The MDS also indicated R15 was at risk for the development of PUs. The PU CAA dated 8/13/13, indicated R15 was at risk for the development of PU's due to urinary incontinence and decreased mobility. The Assessment of Pressure Sore Potential form dated 8/6/13, identified R15 at moderate risk for the development of PUs. The Tissue Tolerance Assessment dated 8/6/13, indicated R15 was able to sit for two hours without redness noted on his skin. R15's POC dated 8/13/13, indicated R15 was at risk for the development of PUs and identified interventions such as pressure reducing mattresses on the bed and wheelchair. However, the POC did not direct the staff as to the frequency to which R15 was to be repositioned. On 9/5/13, a 7:05 a.m. R15 was observed seated in a wheelchair in the main lobby. - At 7:50 a.m. R15 was assisted to the dining room for breakfast. - At 8:24 a.m. R15 wheeled out of the dining room and down the hallway to the main lobby. R15 was observed to fall asleep in the wheelchair while in the main lobby without receiving assistance. At no time was R15 observed to be able to reposition himself in the wheelchair.	F 314		

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F 314	Continued From page 32 On 9/5/13, at 10:00 a.m. NA-A stated R15 had not received assistance with repositioning since being assisted out of bed. - At 10:33 a.m. NA-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been repositioned since that time. NA-C and NA-A then assisted R15 to bed via a full body mechanical lift. R15's wheelchair was observed to be equipped with a pressure redistribution cushion. R15's skin was observed to be pink and intact free of pressure ulcers. - At 10:40 a.m. NA-C confirmed R15 had not received assistance with repositioning between 6:30 a.m. and 10:33 p.m. a total of 4 hours and 3 minutes. On 9/5/14, at 12:35 p.m. registered nurse (RN)-A stated R15 was to receive assistance with repositioning every two hours. R55 did not receive timely assistance with repositioning and had a history of PUs. R55's diagnoses included Alzheimer's disease, a stroke and dementia. The quarterly MDS dated 6/25/13, indicated R55 had severe cognitive impairment and required extensive assistance with bed mobility, total assistance with transfers and as being non ambulatory. The assessment also indicated R55 was at risk for the development of pressure ulcers. The PU CAA dated 4/9/13, indicated R55 was at risk for the development of pressure ulcers due to decreased mobility and cognitive impairment.	F 314		

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F 314	Continued From page 33 The Assessment of Pressure Sore Potential form dated 6/21/13, indicated R55 was at risk for the development of PUs. The Tissue Tolerance Assessment form dated 6/21/13, indicated R55 had the ability to sit for up to two hours without the development of redness on her skin. The Skin Risk Assessment and Interventions form dated 6/21/13, indicated R55 had a history of PUs and required staff to assist with repositioning every two hours. R55's POC dated 4/10/13, identified R55 as having a history of PUs. The POC directed staff to assist R55 with repositioning every two hours and as needed. The nurses note dated 8/24/13, indicated the nursing staff had identified two open areas on the left hip. The first area was approximately 2 cm (centimeters) and red in color. The second area was a 0.75 cm dry open area in the middle of the first area. The nursing staff applied a Exuderm dressing (thin protective dressing) over the area and planned to monitor until the area had resolved. On 9/5/13, at 7:05 a.m. R55 was observed in the main lobby, seated in a wheelchair. A full body mechanical lift sheet was positioned under the resident. - At 7:35 a.m. R55 was observed to be assisted to her room by a laboratory staff member. - At 7:45 a.m. R55 was returned to the lobby area. - At 7:55 a.m. R55 was assisted to the South dining room for breakfast.	F 314		

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F 314	Continued From page 34 - At 8:32 a.m. R55 was wheeled from the dining room to the main lobby area. R55 remained in the lobby area until 9:50 a.m. at which time NA-A and NA-C assisted R55 to bed via a full body mechanical lift. R55's wheelchair was observed to be equipped with a pressure redistribution cushion. A protective dressing was observed to be intact over the left hip. On 9/5/13, at 10:00 a.m. NA-A confirmed R55 had been assisted out of bed at 7:00 a.m. and had not received assistance with repositioning since that time. A total of two hours and 50 minutes earlier. On 9/5/13, at 12:40 p.m. RN-A stated R55 was at risk for the development of pressure sores and was to be repositioned every two hours. At 2:50 p.m. RN-A observed R55's left hip and identified the protective dressing on the left hip. RN-A refused to remove the dressing to assess R55's skin at that time. On 9/6/13, at 12:30 p.m. the DON reported the dressing from the left hip had been removed and the open area had resolved. R29 was identified at risk for the development of PUs and was not provided timely assistance with repositioning on the morning of 9/5/13, for three hours and 11 minutes. R29's diagnoses included anxiety, dementia with behavioral disturbances and paranoia. The quarterly MDS dated 7/9/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living, including extensive assistance with bed	F 314		

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F 314	Continued From page 35 mobility and total assistance with transfers. The MDS also indicated R29 was at risk for the development of PUs. The PU CAA dated 4/21/13, also identified R29 at risk for the development of PUs. R29's POC dated 7/17/13, indicated R29 was at risk for skin breakdown and directed staff to assist with repositioning every two hours. The Assessment of Pressure Sore Potential form dated 7/8/13, identified R29 as being at high risk for the development of PUs. The Skin Risk Assessment and Interventions form dated 7/8/13, identified R29 at high risk for the development of PU and directed staff to assist with repositioning every two hours while sitting or supine. On 9/5/13, at 7:10 a. R29 was observed resting in bed on his back. R29 was observed to remain in bed, on his back until 9:10 a.m. at which time R29 was observed to receive assistance with morning cares. R29's skin was observed to be intact. At 9:20 a.m. R29 was transferred from the bed via a full body mechanical lift with the assistance of NA-A and NA-C. On 9/5/13, at 9:40 a.m. NA-C stated R29 had been last assisted with repositioning at 6:00 a.m. a total of 3 hours and ten minutes earlier. On 9/5/13, at 1:00 p.m. RN-A stated R29 was to receive assistance with repositioning every two hours as directed by the POC. The Skin Assessment policy revised on 8/06, and	F 314		

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F 314	Continued From page 36 the Repositioning policy revised on 6/2011, directed the staff to provide assistance with repositioning as directed by the resident's individual assessment.	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents identified at risk for urinary incontinence received timely assistance with toileting and incontinence care for 3 of 4 residents (R38, R15 and R29) in the sample identified as incontinent based on the comprehensive assessment. Findings include: R38 was incontinent of urine and did not receive incontinence care as directed by the plan of care (POC). R38's diagnoses included a history of pressure ulcers, arterial disease and peripheral vascular disease (PVD, a circulatory problem).	F 315	It is the policy of FCLC to prevent UTI's and restore as much normal bladder function as possible. A. Comprehensive assessment reviewed and care plan revision as appropriate for residents R29, R15, R38 B. RNCC or her designee will audit incontinence management of R29, R15, R38 according to their individualized plan of care weekly x 4 weeks then on a random basis. C. Random audits for all other residents will be completed weekly x 4 weeks then on a random basis by RNCC or her designee to ensure ongoing compliance with incontinence management and individualized toileting interventions. D. RNCC will review/revise as appropriate bowel and bladder assessments for all residents on admit, quarterly, with significant changes in continence. E. RNCC or their designee will follow the TENA products policy and procedure for incontinence management and will design individualized toileting programs for all residents who would benefit from these interventions.	

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F 315	Continued From page 37 The quarterly Minimum Data Set (MDS) dated 6/25/13, indicated R38 was cognitively intact. The bladder assessment dated 6/25/13, indicated R38 refused a toileting program and staff continued to change incontinent brief per manufacturer's recommendations. The Urinary Incontinence Care Area Assessment (CAA) dated 9/5/13, indicated R38 had episodes of bladder incontinence. R38's POC dated 7/3/13, directed staff to provide incontinent cares every 2-3 hours during the day. On 9/5/13, at 7:05 a.m. R38 was observed asleep on her back in bed. R38 was continuously observed in bed, on her back until 10:09 a.m. - At 10:09 a.m. nursing assistant (NA)-A and NA-C entered R38's room. - At 10:11 a.m. NA-C stated her and NA-A were the NAs assigned to the South wing. - At 10:15 a.m. NA-C stated R38's brief was changed at 7 a.m. and R38 was incontinent of urine at that time. NA-C stated the R38's incontinent brief was to be changed every 2 hours. - At 10:20 a.m. NA-C changed the brief and R38's incontinent product was observed saturated with urine. (3 hours and 20 minutes after the last brief change). On 9/5/13, at 1:02 p.m. registered nurse (RN)-A stated R38 was to receive incontinence cares every 2-3 hours during the day. RN-A verified the POC was not followed.	F 315	CONTINUED F315-E F. Education for all staff on P and P for incontinence management and compliance with the individualized toileting schedule by Mandatory Licensed Staff Meeting on October 9, and Mandatory All Staff meeting on October 10, 2013. G. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. H. Compliance reported to QAPI meetings quarterly.	

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F 315	Continued From page 38 R15 did not receive assistance with incontinence cares for greater than four hours on the morning of 9/5/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive impairment and required extensive assistance with activities of daily living. The MDS also indicated R15 was frequently incontinent of bowel and bladder. The Urinary Incontinence CAA dated 8/13/13, indicated R15 was frequently incontinent of bowel and bladder and directed staff to assist with incontinence cares every two hours. The B & B H& P (Bowel and Bladder History and Physical) Assessment dated 8/6/13, indicated R15 was incontinent of bowel and bladder and required extensive assistance of two staff to use the toilet. It directed the staff to assist R15 with incontinence cares every two hours. R15's POC dated 8/13/13, directed staff to assist with incontinence cares every two hours. On 9/5/13, a 7:05 a.m. R15 was observed in the main lobby seated in a wheelchair. - At 7:50 a.m. R15 was observed to be assisted to the dining room for breakfast. - At 8:24 a.m. R15 wheeled out of the dining room and down the hallway to the main lobby. R15 was observed to fall asleep in the wheelchair while in the main lobby without receiving assistance. On 9/5/13, at 10:00 a.m. NA-A stated R15 had not received assistance with incontinence since he got out of bed before breakfast.	F 315		

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F 315	Continued From page 39 At 10:33 a.m. NA-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been assisted with incontinence cares since that time. NA-C and NA-A were then observed to assist R15 to bed via a full body mechanical lift. R15 was observed to be wearing an incontinence product which was saturated with urine. At 10:40 a.m. NA-C confirmed R15 had not received assistance with incontinence cares between 6:30 am. and 10:33 p.m. a total of four hours and three minutes. On 9/5/14, at 12:35 p.m. RN-A stated R15 was to receive incontinence cares every two hours as directed by the POC. R29 did not receive timely assistance with incontinence cares on the morning of 9/5/13. R29's diagnoses included anxiety, dementia with behavioral disturbances and paranoia. The quarterly MDS dated 7/9/13, indicated R29 had severe cognitive impairments and required extensive assistance with all activities of daily living. The MDS also identified R29 as being totally incontinent of bladder. The Urinary Incontinence CAA dated 4/21/13, identified R29 as being totally incontinent of bladder. R29's POC dated 7/17/13, directed staff to assist with incontinence cares every two hours. The B&B H&P assessment dated 7/8/13, identified R29 as being totally incontinent of bladder and required assistance of staff to provide incontinence cares every two hours.	F 315		

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F 315	Continued From page 40 On 9/5/13, at 7:10 a. R29 was observed resting in bed on his back. R29 was observed to remain in bed, on his back until 9:10 a.m. at which time R29 received assistance with morning cares from NA-A and NA-C. R29 was observed to be incontinent of bladder at the time of morning cares. On 9/5/13, at 9:40 a.m. NA-C stated R29 had been last assisted with incontinence cares at 6:00 a.m. a total of three hours and ten minutes earlier. On 9/5/13, at 1:00 p.m. RN-A stated R29 was to receive assistance with incontinence cares every two hours as directed by the POC. The Bladder and Bowel Assessment policy dated 12/05 and revised on 11/06 directed the staff if a resident was incontinent with no control present with the inability to retain, the resident was to receive assistance with having the incontinent product check every two hours and changed as needed.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323	It is the policy of FCLC to ensure resident receives adequate supervision and assistance devices to prevent accidents. A. Enabler bar assessments completed for all residents who utilize enabler bars and care plan revision as appropriate to reflect individualized needs. B. SSD to ensure resident/family notification of risk/benefits and potential hazards of enabler bar use. C. All enabler bars with exposed bolt heads have been repaired and are compliant effective 9-17-13.	

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F 323	Continued From page 41 Based on observation, interview and document review, the facility failed to ensure an enabler bar was safe to use for 2 of 2 residents (R38, R42) in the sample. In addition, the facility failed to ensure enabler bars were assessed for resident safety which had the potential to affect 17 residents (R38, R42, R37, R56, R33, R20, R59, R13, R26, R48, R23, R58, R44, R57, R6, R52, R2) who utilized enabler bars. Findings include: R38 was diagnosed with arterial disease and peripheral vascular disease (PVD, a circulatory problem). The quarterly Minimum Data Set (MDS) dated 6/25/13, indicated R38 was cognitively intact and required extensive assistance of two staff for bed mobility and transfers. R38's plan of care (POC) dated 7/3/13, indicated R38 used enabler bars on the bed to increase her bed mobility. On 9/4/13, at 9:59 a.m. bilateral enabler bars were observed on R38's bed. In the center of the rail a horizontal PVC pipe (a combination pipe made from plastic and vinyl) was observed which ran left to right on the bar. The PVC pipe had 2 screws on the end of the enabler bar that were sharp to the touch. R38 stated the rails were sharp and stated a couple of times she had sustained skin tears from the rails. An undated incident report indicated a nursing assistant (NA) observed a skin tear on R38s right upper arm covered with dried blood. After cleansing, it was noted there were three separate	F 323	CONTINUED F323-E D. IDT/ Therapy will perform environmental screen for all resident needs for enabler bars as a positioning device on admit, quarterly, and with significant changes. E. DON will audit enabler bars for depth of openings to ensure less than 4" between openings and for exposed bolt heads weekly x 4 weeks and monthly thereafter on all residents utilizing enabler bars. F. Education provided to all facility staff on enabler bar safety by Mandatory Licensed Staff meeting October 9 and Mandatory All staff meeting October 10, 2013. G. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. H. Compliance reported to QAPI meetings quarterly.	

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F 323	Continued From page 42 tears in a row with the one closest to the elbow which measured 1.0 centimeter (cm), next 0.5 cm and at the top there was a "V"-shaped tear measuring 0.75 cm on each side of the "V." On 8/9/13, the nursing progress notes indicated a NA had observed a skin tear on R38's upper outer arm. Had dried blood over the area and was difficult to cleanse adequately due to fragile skin. The note indicated the NA had asked R38 how this had occurred and the resident stated she had bumped her arm on her enabler bar during the previous night. The note also indicated there were three tears in a line. This was documented by licensed practical nurse (LPN)-D. On 9/6/13, at 9:47 a.m. LPN-B verified the 8/9/13, incident report was undated when printed. LPN-B stated the entry for the incident report was date stamped on the computer. LPN-B then printed the corresponding nursing progress note. On 9/6/13 at 10:10 a.m. the director of nursing (DON), stated she had not realized R38's skin tears were from the enabler bar. The DON stated LPN-D had not documented on the incident report the skin tears were from the enabler bar and stated she would have had to read the nurses notes to know it was from the enabler bar. On 9/6/13, at 10:32 a.m. the social service designee (SSD) stated she had spoken with R38 after the incident and R38 had told the SSD she had been bumped on the enabler bar . R42's diagnoses included explosive personality disorder and depression. The quarterly MDS dated 8/6/13, indicated R42 had moderate cognitive impairment and required extensive	F 323		

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F 323	Continued From page 43 assistance with activities of daily living including bed mobility. The Pressure Ulcer Care Area Assessment (CAA) dated 5/22/13, indicated R42 utilized enable bars on the bed to assist in turning and repositioning. The CAA also indicated R42 was was able to turn from side to side in the bed independently and required extensive assistance to go from a supine to sitting position. R42's POC dated 2/27/13, indicated R42 utilized bilateral enable bars to aid with turning repositioning and bed mobility and to aide in independence. The Alternative Device form dated 4/26/13, identified R42 as having enabler bars in place. The reason for the bars and the date which they were placed was not identified on the form. The form stated the bars were in place prior to the implementation of the Alternative Device form which was started on 4/26/13. On 9/3/13, at 6:10 p.m. R42's bed was observed to be equipped with two large "U" shaped enabler bars. The bars were observed to have been adapted with one PVC pipe that ran from left to right on the bar. The space which the PVC pipe created between the pipe and the bed frame was large. The edges of the pipe were held in place with screws which were sharp to the touch and the edges of the pipe were not secure to the inner aspect the bar causing it to move up and down, exposing rough edges of the pipe. On 9/5/13, at 2:15 p.m. RN-A stated the maintenance department had visualized the enabler bars to ensure appropriate size for resident use. RN-A stated she was aware R42	F 323		

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	245512	A. BUILDING _____ B. WING _____	09/06/2013

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F 323	Continued From page 44 used his bars for bed mobility, but at no time did the facility complete assessments on the bars to ensure they were safe for the residents. At 2:30 p.m. RN-A measured the spaces between the PVC pipe and the bed frame. RN-C reported the space was greater than 8.0 inches. RN-C verified the tape around the main U shape on the right bar was peeling away and that the screws and edges of the PVC pipe were rough and residents could potentially become injured. The Federal Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment guidance to Reduce Entrapment dated 3/10/06, indicated the space between the bed rails was not to exceed 4 3/4 inches. On 9/6/13, at 9:20 a.m. maintenance staff member (MS)-A stated when ordered by the facility, the enabler bars were large U shaped bars with no additional bars in them to decrease the space between the rails. He explained the facility staff members had added two PVC pipes to each of the rails to ensure the space between the rails did not exceed 4 3/4 inches. He stated he was unaware why R42's rails only had one PVC pipe. He stated it should have two PVC pipes. On 9/6/13, at 9:30 a.m. the director of environmental services (DES) stated the facility had purchased several rails about seven years ago. The DES stated the facility had required more rails over the years therefore, some of the maintenance staff had fabricated matching rails. He explained the PVC pipes had been added to all of the rails to decrease the spaces for potential entrapment. He stated all of the rails with a singe PVC pipe should have been removed and they	F 323		

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F 323	Continued From page 45 should all be equipped with two PVC pipes. He stated the facility did not have any manufacture documentation regarding the rails and stated all of the original manufactured rails had been altered in an attempt to reduce the rails. The DES added the facility was currently in the process of reviewing new bed options which were equipped with enabler bars and they had received approval for them. However, they were not currently in house and alternative enabler bars were not available. On 9/6/13, at 12:00 p.m. licensed practical nurse (LPN)-A provided a list which identified the facility currently had 17 resident beds equipped with enabler bars which had either been altered from the manufacturer's original design or fabricated by staff. The list indicated R38, R42, R37, R56, R33, R20, R59, R13, R26, R48, R23, R58, R44, R57, R6, R52, and R2 all had altered rails on their beds. The 1/2 side Rail/Enabler Use in LTC (long term care) policy dated 7/11, directed the staff to assess the resident upon admission for the use of 1/2 side rails/enablers. The policy did not direct the staff to ensure the rails were safe for the residents.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353	It is the policy of FCLC to ensure adequate productive nursing staff and nursing assistants each shift in compliance with state and federal regulations.	

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F 353	Continued From page 46 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure sufficient qualified nursing staff were available to meet the residents' needs for nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 47 residents residing in the facility. Findings include: During the survey conducted on 9/3/13, from 11:30 a.m. until 8:00 p.m. and 9/4/13, from 8:00 a.m. until 4:30 p.m. 9/5/13, from 7:00 a.m. until 3:30 p.m. and on 9/6/13, from 8:00 a.m. until 4:30 p.m. respectively, staff were observed to not be able to consistently provide services for the residents as directed by their plans of care based on a comprehensive assessment of their needs. The facility failed to provide timely meals in a	F 353	CONTINUED F353-F A. Standardized nursing day will be audited weekly by HUC and DON. This is the sum of the number of residents in each case mix class x the case mix weight for that class, calculated on the basis of a facility's census. Calculation of nursing hours is performed by dividing total hours of nursing personnel by the standardized resident days. B. Budgeted staffing averages at 5.1 direct care staff hours per resident days. C. Case mix calculations will be done weekly, and with each admit or case mix change to ensure proper number of staff person scheduled. D. Challenges with staffing emergencies will be handled by adjusting staff. Direct care staff to notify all available licensed staff to assist with resident care. COTA and PTA will assist with restorative nursing duties. Unlicensed personal will assist with housekeeping/bed making. E. Weekly case mix reports to Clinical Services Director and Administrator. F. Education provided to all facility staff on staffing interventions by Mandatory Licensed Staff meeting on October 9, and Mandatory All Staff Meeting on October 10, 2013	

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F 353	Continued From page 47 manner which promoted dignity for 3 of 3 residents (R13, R29, R15) in the sample who did not receive breakfast. See F241. The facility failed to provide ambulation services according to the assessed need for 1 of 1 resident (13) in the sample. See F311. The facility failed to ensure a resident identified at risk for pressure ulcers (PU) received timely repositioning for 4 of 5 residents (R38, R15, R55 and R29) in the sample identified at risk for pressure ulcers. See F314. The facility failed to ensure residents identified at risk for urinary incontinence received timely assistance for 3 of 4 residents (R38, R15 and R29) in the sample identified as incontinent based on the comprehensive assessment. See F315. Staffing reports were reviewed for the previous five weeks. (8/1/13 - 9/6/13). The facility staffing pattern determined the day shift required two nursing assistants (NA), two nursing assistants to work as NA and as a universal worker, two NAs to complete restorative exercises and one NA designated to assist residents with baths. Two licensed nurses routinely did medication administration, documentation, and other non-direct care nursing duties, but were available to assist NAs with the care of residents if deemed necessary. The evening shift staffing pattern consisted of five NAs to work an eight hour shift and one NA to work a five hour shift along with two licensed staff.	F 353	CONTINUED F353-F G. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. H. Compliance reported to QAPI meetings monthly.	

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F 353	Continued From page 48 The night shift consisted of one licensed staff and two NAs. The staffing report for August 2013, identified 31 days of which 12 days were without shortages and 20 days (8/1, 2, 3, 4, 5, 7, 8, 9, 11, 16, 17, 20, 22, 23, 25, 26, 27, 29, 30, 31) nursing assistant staff had shortages of 1 - 3 staff members. In September from 9/1/13 - 9/6/13, the facility had daily staffing shortages of 1-3 staff. Of the projected nursing schedule from 9/7/13 - 9/22/13, the facility had six days (9/9, 12, 14, 15, 17, 18) in which the nursing staff were to work with 1 -2 nursing assistants short. On 9/3/13, at 4:15 p.m. R59 an alert and oriented resident, reported the facility was frequently short staffed in the morning. R59 explained he would like to get up around 6:30 a.m. but the facility did not seem to have enough staff to help him. On 9/3/13, at 5:38 p.m. R47, an alert and oriented resident stated it took a long time for the staff to answer lights in the morning, but felt that was part of living in a nursing home. On 9/5/13, at 7:00 a.m. the facility was staffed with five nursing assistants (instead of seven) and two medication nurses. As support staff arrived at the facility, licensed practical nurse (LPN)-A assisted in the dining room. Registered nurse (RN)-A, LPN-D/social service designee, and the director of nurses (DON) were not observed to assist the NAs who were providing direct care. On 9/5/13, at 12:04 p.m. NA-C stated the facility was short a nursing assistant and she was running behind. She stated when the support staff	F 353		

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F 353	Continued From page 49 such as the registered nurses doing paper work, the licensed practical nurses (LPN) who worked as the social service designee and the ward clerk and the director of nurses arrived at the facility, they did not check in with the staff on the floor to see how things were going. NA-C stated they may check in with the wing nurses and LPN-A assists with the dining room, but they do not routinely assist with providing cares on the floor. NA-C stated the facility was frequently short staffed. NA-C added she and NA-A had 22 residents assigned to them to provide morning cares to. Of those 22 residents,13 of the residents required assistance of two staff for some or all of the morning cares and only two residents were completely independent with their morning routine. On 9/5/13, at 12:11 p.m. NA-A stated the facility has been short staffed for the past few weeks. He stated the nursing staff will help when they can but they do not consistently ask if the NAs on the floor need help. On 9/5/13, at 12:20 p.m. LPN-A stated each morning she assists the residents in the north dining room and will help the staff whenever she had a chance. She stated she was aware at 7:30 a.m. that the staff on the floor were two nursing assistants short, but she was unable to help due to meeting. On 9/5/13, at 12:44 p.m. RN-A stated she had arrived at the facility at 8:40 a.m. and had been made aware the facility was two NAs short. She stated on a regular day she would be informed about such concerns around 10:00 a.m. during morning report. She stated she could easily help the staff on the floor but had not been asked to	F 353		

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F 353	Continued From page 50 assist. She stated she was unable to assist the morning of 9/5/13, because of a meeting. She stated the facility had occasional short staffing patterns and the charge nurses called as many staff as they could to try to find assistance to cover the shift. On 9/5/13, at 1:00 p.m. LPN-C who was working the South cart stated the LPN's try to help the NAs on the floor as much as possible. She stated LPN-A usually helped with meals, but the other licensed nurse did not consistently help unless asked. On 9/5/13, at 1:15 p.m. a nursing staff member who requested to remain anonymous stated the facility was short staffed quite frequently. The staff member explained that in the past week, the facility had 17 shifts which were not filled, one death, one planned discharge and five new admissions. The staff member stated the support licensed staff (LPN-A, LPN-D/SSD, RN's and DON) may check in with the charge nurses, but they do not assist with cares. The staff stated LPN-A would assist with meals. On 9/6/13, at 7:16 a.m. NA-A stated the facility had four NAs, a bath aide and a float (total of six). The facility was short one nursing assistant. On 9/6/13, at 7:43 a.m. restorative aide (RA)-A stated she ended up working the floor as a nursing assistant 2-3 days a week to provide direct care for the residents. She stated she was not consistently able to complete restorative cares because of providing direct care support. During an interview with the DON on 9/6/13, at 8:25 a.m. the DON explained each morning she	F 353		

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F 353	Continued From page 51 and LPN-A reviewed the staffing patterns. She stated the facility was currently going through a difficult transition due to employee illness and some staffing changes. She explained LPN-A and the DON did not leave the facility "short short." When questioned as to the definition of short short, the DON did not respond. She explained based on the statistical findings, the facility was still meeting the needs of the residents. When questioned if the current residents were receiving cares, she stated she was unaware of any concerns. The DON confirmed in the past seven days, the facility had one planned discharge, one death and four new admissions. Upon review of the staffing pattern, the DON confirmed the facility was not currently meeting the established staffing pattern. On 9/6/13, at 10:40 a.m. LPN-D stated she assisted the staff on the floor when possible and assisted with filling the open shifts. She stated all of the staff assist with picking up shifts and according to the statistical findings, the facility was meeting the required staffing ratios. A policy regarding sufficient staff was requested, but not provided.	F 353		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for	F 411	A. Comprehensive assessment and care plan revision as appropriate for resident R42 to reflect level of assistance needed for oral cares. B. RNCC revision of Care plans as appropriate for all residents to reflect current observations/interventions.	

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F 411	Continued From page 52 routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide an oral assessment to meet the needs for 1 of 2 residents (R42) in the sample reviewed for dental concerns. Findings include: R42's diagnoses included explosive personality disorder and depression. The quarterly Minimum Data Set (MDS) dated 8/6/13, indicated R42 had moderate cognitive impairment and required extensive assistance with activities of daily living. The annual MDS dated 5/14/13, indicated staff were unable to examine R42's teeth at the time of this assessment. The Dental Care Area Assessment (CAA) was not identified as a concern therefore, was not completed at the time of the assessment. The plan of care dated 2/27/13, indicated R42 was missing several teeth and required limited to extensive assistance with activities of daily living including oral care. The Nutritional Assessment dated 9/4/13, did not identify R42 as having any concerns with eating and did not address the condition of R42's teeth.	F 411	CONTINUED F411-D C. Dental exam declined by resident R42 and his POA. SSD/TREC will review status with resident and family during care plan conferences quarterly. D. Nursing staff will attempt oral cavity mucosa check on bath day and PRN as resident allows. Primary Physician notified on rounds of refusal of oral checks. E. RNCC will complete dental assessment and care plan revisions as appropriate on all residents on admit, quarterly, and with significant changes. F. Education provided to all facility staff on compliance with oral care exams by Mandatory Licensed Staff meeting on October 9, and Mandatory All Staff Meeting on October 10, 2013. G. Education provided in an informational package to staff not attending to be completed prior to their next scheduled shift and to all new employee orientation. H. Compliance reported to QAPI meetings quarterly.	

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F 411	Continued From page 53 Review of the Use New Admit/ Temporary Care Plan dated 7/16/09, identified R42's teeth as being "ample." A Eye and Dental Services form dated 7/16/09, indicated R42's guardian had not desired R42 to have dental exams while at the facility. The clinical record did not include any type of comprehensive oral assessment in which the nursing staff may have assessed R42's teeth in order to monitor for changes or possible concerns. On 9/3/13, at 7:45 p.m. R42 was observed to have multiple darkened areas on his lower teeth and several teeth missing from his mouth. On 9/5/13, at 7:00 a.m. R42 was observed siting by the breakfast table. At 8:00 a.m. R42 received his breakfast meal of a boiled egg and toast. R42 was observed to eat the meal items independently without complaints. On 9/5/13, at 2:13 registered nurse (RN)-A stated R42's guardian had not desired R42 to receive dental services. RN-A explained the residents teeth area were usually reviewed during the annual MDS or assessment period but R42 was uncooperative with most of the MDS evaluation. On 9/5/13, at 2:41 p.m. RN-A confirmed R42 had multiple broken lower teeth but had not looked at the upper portion of R42's mouth and had no idea if R42 had upper teeth or not. RN-A stated R42 may have complaints of pain which would have bee treated with Tylenol. RN-A stated R42 had not expressed complaints of pain in the past two	F 411		

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F 411	Continued From page 54 months. RN-A confirmed R42 had not received a comprehensive oral assessment by the nursing staff. On 9/6/13, at 7:08 a.m. R42 stated it had been several years since he had been to the dentist. He stated that some of the back teeth on the lower right side had "uncapped themselves." R42 explained if he had pain, he would tell the nurse about the concerns and that he only had difficulty with hard foods such hard meats. R42 stated the food at the facility was soft enough for him to be able to chew. On 9/6/13, at 10:00 a.m. nursing assistant (NA)-C stated R42 usually refused assistance with oral cares and was unaware if R42 completed the oral cares independently. On 9/6/13, at 11:06 a.m. RN-C stated the facility had not routinely checked resident's oral cavities beyond the MDS assessment. RN-C reviewed R42's record and confirmed the facility had not competed an oral assessment which would indicate any changes in R42's mouth. A policy regarding oral assessments was requested but not provided.	F 411		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441	A. A written warning and counseling was completed by September 20 for staff members that were involved with infection control measures with resident R29. B. DON performed audit and check off of skills competency of hand washing practices and wound dressing changes with LPN involved with wound care of resident R38.	

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F 441	Continued From page 55 The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control technique was maintained for 1 of 1 resident (R38) observed receiving a pressure ulcer dressing change. In addition, the staff failed to wash their hands after perineal care for 1 of 4 residents (R29) observed receiving perineal care.	F 441	CONTINUED F441-D C. All Licensed Nursing staff educated on the Mosby's skills for wound care per facility policy. D. HUC or her designee to perform Handwashing audits on 4 staff persons on each community weekly x 4 weeks and monthly thereafter. E. Quarterly report to infection control committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING _____ B. WING _____	09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 56 Findings include: On 9/4/13, at 2:47 p.m. R38 was observed in bed. Licensed practical nurse (LPN)-A was observed to apply gloves. LPN-A was not observed to wash her hands prior to applying the gloves. LPN-A lifted R38's right leg and placed it on a pillow. R38s right foot was observed wrapped with kling. - At 2:48 p.m. LPN-A left the room and touched the door with her gloved hand, then immediately returned and took her medication cart key out of the lock in R38's night stand and then left the room again to get a scissor out of the medication cart in the hallway. LPN-A had not removed her gloves, washed her hands nor apply clean gloves. - At 2:49 p.m. LPN-A cut the kling off the right foot with the scissor. There was a telfa pad on the right malleolus (ankle bone). There was a black spot on the second and fifth toe. There was also a scabbed area on the heel. LPN-A removed the telfa pad from the right malleolus and an open area was observed. - At 2:51 p.m. LPN-A went into the bathroom and obtained a wet wipe. LPN-A then wiped dried blood from between the 4th and 5th toe. LPN-A then removed her gloves and went into the bathroom and applied new gloves. No hand washing was observed. - At 2:53 p.m. LPN-A opened up a telfa dressing package and applied Santyl (debriding) ointment on the dressing. - At 2:54 p.m. LPN-A removed her gloves and left the room and went to the medication cart in the hallway. LPN-A then went to the supply closet across the hall and returned with a bottle of wound cleanser and gauze. When LPN-A re-entered the room she did not wash her hands	F 441		

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F 441	Continued From page 57 and then applied gloves. - At 2:57 p.m. LPN-A cleansed the open area on the right malleolus with wound cleanser, and applied the telfa dressing. - At 2:58 p.m. LPN-A left the room with her gloves on, touched the door, and then brought her medication cart into the room. - At 2:59 p.m. LPN-A then removed her gloves and laid them on the top of the medication cart and checked the treatment order on the computer. - At 3:02 p.m. LPN-A went into the bathroom without washing her hands and applied gloves. - At 3:03 p.m. LPN-A wrapped the right foot with kling and applied tape. - At 3:05 p.m. LPN-A removed her gloves and placed them in the garbage can next to the bed. - At 3:06 p.m. LPN-A bagged up the garbage in the room - At 3:08 p.m. LPN-A put the bagged garbage in the soiled utility room and did not wash her hands. - At 3:10 p.m. nursing assistant (NA)-G and LPN-A were going to check R38 for incontinence. - At 3:11 p.m. LPN-A went into the bathroom and applied gloves. - At 3:13 p.m. LPN-A bagged up the soiled brief that was in the garbage can and assisted to pull up R38s pants. - At 3:15 p.m. LPN-A removed her gloves and washed her hands in the bathroom. LPN-A shut the faucet handles off with both of her hands that she had just washed. - At 3:17 p.m. LPN-A put the garbage bag in the soiled utility room. On 9/4/13, at 3:18 p.m. LPN-A stated she was not organized at all for the dressing change. LPN-A stated she should have washed her hands or	F 441		

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F 441	Continued From page 58 used hand sanitizer after removing the soiled dressing and applying the new dressing. LPN-A stated there was hand sanitizer in the room she could have used. LPN-A stated normally she would not have left the room that many times. LPN-A stated she had used a scissor from the medication cart for the dressing change, and was unsure if it was clean. LPN-A stated she did not clean the scissor with alcohol prior to using it. On 9/6/13, at 10:36 a.m. the director of nursing stated staff were to wash their hands or use hand sanitizer after removing gloves. The Hand Washing Policy revised 5/04, indicated staff were to decontaminate their hands before having direct contact with patients. Decontaminate hands after having contact with wound dressings. Decontaminate hands after removing gloves. R29 did not receive personal cares with appropriate hand washing on the morning of 9/5/13. R29's diagnoses included anxiety, dementia with behavioral disturbances and paranoia. The quarterly Minimum Data Set (MDS) dated 7/9/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living, including extensive assistance with bed mobility and personal hygiene. R29's plan of care (POC) dated 7/17/13, indicated R29 was unable to care for himself with activities of daily living such as bathing, grooming, dressing and transferring. The POC directed the	F 441		

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F 441	Continued From page 59 staff to provide assistance with 1 -2 staff members. On 9/5/13, at 9:00 a.m. NA-A and NA-C entered R29's room to assist with morning cares. - At 9:07 a.m. NA-C donned gloves and assisted R29 with washing his face, hands and upper body. NA-A assisted R29 with repositioning as needed to complete the cares. - At 9:11 a.m. NA-C rolled R29 onto his right side and assisted with perineal cares. R29 was observed to be incontinent of urine and had a small bowel movement. NA-C was not observed to remove the soiled gloves prior to applying a fresh incontinent brief. NA-C was observed with the same gloved hands to move the privacy curtain, open the bathroom door and place the soiled towels in a bag and then returned to R29 and assisted with dressing. She left her gloves on as she put on R29's shoes and positioned a full body mechanical lift sheet under the resident. - At 9:20 a.m. NA-C moved R29's wheelchair and assisted NA-A with connecting the full body lift to the lift sheet. - At 9:22 a.m. NA-C assisted to guide R29 into the wheelchair with the same soiled gloves on. NA-C tucked the lift sling under R29 and walked into the bathroom, removed the gloves and washed her hands. On 9/5/13, at 9:40 a.m. NA-C confirmed she had left the soiled gloves on while she completed dressing R29 and moving items in the room. On 9/5/13, at 1:00 p.m. RN-A stated NA-C should have removed her gloves and washed hands prior to touching multiple areas in the room. The Hand Hygiene policy revised on 2/2010,	F 441		

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F 441	Continued From page 60 directed staff to change gloves when moving from a contaminated body site to a clean body site on the same resident. The policy also directed the staff to "always" wash their hands after the removal of gloves.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain resident bathroom walls in a clean and sanitary condition free from black scuff marks for 7 of 28 resident bathrooms and 2 of 28 resident bedrooms free from gouged, scratched walls. Findings include: During the environmental tour on 9/6/13, at 9:30 a.m. with the director of environmental services (DES) the following was observed: Room #101 had multiple areas of dark scuff marks on the bathroom walls. Room #105 had multiple areas of dark scuff marks on the bathroom walls. Room #106 had multiple areas of dark scuff marks on the bathroom walls. Room #107 had multiple areas of dark scuff marks on the bathroom walls. Room #108 had multiple areas of dark scuff	F 465	A. All bathroom walls cleaned and in good condition September 9, 2013. B. LTC staff monitor environmental needs/ cleanliness and fill out a maintenance report to maintenance/ housekeepers as needs occur. C. DON will audit bathrooms weekly x 4 weeks and randomly thereafter.	

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F 465	Continued From page 61 marks on the bathroom walls and the wall next to the bed had gouged areas. At this time DES confirmed the gouge marks and stated it could have been from pushing the bed into the wall to clean. Room #128 had multiple areas of dark scuff marks on the bathroom walls Room #129 had multiple areas of dark scuff marks on the bathroom walls and the wall next to the bed had gouged areas. The EDS confirmed the gouge marks and stated it appeared some of the area had been repaired but had been gouged and scratched again before it was ever painted. The DES verified the findings on 9/16/13, at approximately 10:00 a.m. and stated housekeepers had access to magic erasers and they should be using them when they notice these black marks. He added some areas need to be repaired or filled in and then painted. The facility did not provide a policy related to to the maintenance of resident rooms or bathrooms.	F 465		

Essentia Health
Here with you

October 17, 2013

Lyla Burkman RN
Minnesota Department of Health
705 5th St. N.W. Suite A
Bemidji, MN 56601-2933

Dear Ms. Burkman;

This is to amend the plan of correction submitted on October 11, 2013. The addendum to the plan of correction is as follows:

F164 **E.** Audits by Dietary Manager to observe the dietary name cards with each new admit and with any diet order changes to ensure residents personal information is kept confidential.

F241 **G.** North Community nurse & South Community nurse will daily audit meal/snack monitoring forms and will include visual observation at each meal/snack time to ensure all residents are offered nutrition.

F 279 **L.** R24 is the only current dialysis resident at FCLC. FCLC policy revisions to ensure proper care for the resident undergoing kidney dialysis. Revisions to policy include Fistulas will be checked each shift, what to do in case of emergency or inclement weather, not to take b/ps on arm with fistulas and the incorporation of Sanford dialysis care plan into residents FCLC care plan.
M. DON will ensure the care plan of any new dialysis resident follows the FCLC policy and will perform chart audits of all dialysis residents monthly.

F 280 **F.** RNCC or her designee will audit by visual observation resident R29 oral cares weekly x 4 weeks and randomly thereafter.

F 282 **H.** Random audits for all other residents will be completed by visual observations weekly x 4 weeks then on a random basis by RNCC's or their designee to ensure ongoing compliance with repositioning, incontinence cares, and ambulation program according to individualized plan of care.

F 311 **C.** RNCC's or their designee will audit the restorative aide documentation weekly to ensure ambulation programs of all residents have been completed according to individualized plan of care.

Fosston
900 Hilligoss Blvd SE
Fosston, MN 56542

T 218.435.1133

EssentiaHealth.org

F 312

B. Visual oral observations of all current residents completed and care plans reviewed and revised as appropriate according to individual oral hygiene needs.
F. RNCC or her designee will audit by visual observations of oral cares weekly x 4 weeks and randomly thereafter for resident R29
G. RNCC or her designee will audit by visual observation incontinence cares weekly x 4 weeks and randomly thereafter for resident R15.
H. Random audits by visual observations for all other residents will be completed weekly x 4 weeks then on a random basis by RNCC or her designee to ensure ongoing compliance with oral cares and incontinent cares.

F 314

D. RNCC or her designee will audit repositioning by visual observations and monitoring tool per FCLC policy weekly x 4 weeks then on a random basis to ensure ongoing compliance for residents R29, R38, R15, R55.
E. Random audits of all other residents by visual observations and monitoring tool per FCLC policy weekly x 4 weeks and then on a random basis by RNCC or her designee to ensure ongoing compliance with repositioning according to individualized plan of care.

F 315

B. RNCC or her designee will audit by visual observation incontinence management of R29, R15, R38, according to their individualized plan of care weekly x 4 weeks then on a random basis thereafter.
C. Random audits by visual observation for all other residents will be completed weekly x 4 weeks then on a random basis by RNCC or her designee to ensure ongoing compliance with incontinence management and individualized toileting interventions.
E. RNCC will follow policy and procedure of FCLC to check incontinent product at time of toileting and changed per manufacturers guidelines. In service training on manufacturers' guidelines for nursing staff by manufacturer representative scheduled on November 6, 2013.

F 323

I. Eliminate the use of the current Enabler Bars upon arrival of the purchased new LTC beds.

F 353

D. Daily review of attendance records by charge nurse to determine if adjustments in staff need to be made daily to assignment sheets. All available licensed staff will be reassigned to assist with direct resident care. COTA and PTA will assist with restorative nursing duties. Unlicensed personal will assist with housekeeping/bed making. Monetary incentives are offered to staff who pick up additional unscheduled shifts.

F 411

E. RNCC will complete dental assessment which will include visual observations to review and revise care plans as appropriate on all residents on admit, quarterly and with significant changes.

F 465 C. DON will audit by visual observations bathrooms weekly x 4 weeks and randomly thereafter.

Correction dates for all deficiencies will be November 8, 2013

Feel free to contact me if there are any questions or concerns at (218) 435-7630 and thank you for the opportunity to amend the plan of correction.

Sincerely,

Kevin Gish
Chief Executive Officer

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

F5512022

PRINTED: 09/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, First Care Living Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	POC FS 10-23-13 RECEIVED OCT 16 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 09.06.2013 DC: 10.16.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen D. Smith, LNHA	Administrator	10-11-2013

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 Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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 First Care Living Center is a 1-story building without a basement. The building was constructed at 2 different times. The original building was constructed in 1972 and was determined to be of Type II(111) construction. In 1997, additions to the sleeping rooms and an activates room to the north east corner were constructed. Theses additions are Type II(111) construction. The building is divided into 4 smoke zones with a 30 minute and two 2-hour fire barriers. The entire building is protected with a complete automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems (1999 edition). The facility has a fire alarm system with smoke detection in the corridor system, in all sleeping rooms and in common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The fire alarm	K 000		

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K 000	Continued From page 2 system is monitored for automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility was surveyed as one building. The facility has a capacity of 50 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and testing of doors it was determined that one of the three sets of 1 1/2 hour fire barrier doors between the living center and the other buildings is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1. This deficient practice could allow the products of combustion to travel from one building to another, which will negatively impact all 50 residents, staff and visitors of the facility.	K 011	We ordered and installed a new door coordinator for the door next to the main office on 9/20/13. This door has been tested several times and is meeting compliance. The door will continue to be tested each month during the fire drill.	

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K 011	Continued From page 3 Findings include: Observations and testing of doors during the facility tour on September 5, 2013, between 9:45 am to 11:30 pm, by surveyor 03006, revealed that the coordinator on the cross corridor doors near the main office, between the living center and the hospital did not work properly. The door leafs did not close completely when allowed to become self-closing. The Director of Maintenance verified this finding during the facility tour and with the Administrator during the exit conference.	K 011		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations it was determined that one of the two smoke barrier walls is not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.7.3. This deficient practice could allow the products of combustion to travel from one smoke compartment to another, which will negatively	K 025	The south smoke barrier penetration was sealed using a fire caulking on 9/7/13 by the Maintenance Department. In the future the barriers will be inspected after each contractor to insure they are sealed any time a penetration is made.	

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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
K 025	Continued From page 4 impact all 50 residents, staff and visitors of the facility. Findings include: Observations during the facility tour on September 5, 2013, between 9:45 am to 11:30 pm, by surveyor 03006, revealed that the newly installed yellow wiring that penetrates the south smoke barrier has not be properly sealed and a wiring sleeve was not sealed. The Director of Maintenance verified this finding during the facility tour and with the Administrator during the exit conference.	K 025		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations it was determined that the automatic fire sprinkler system is not complete in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems and	K 056	The South Vestibule has had a new sprinkler head added by Dakota Fire on 9/20/13. All areas of the building are fully sprinkled.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245512	A. BUILDING **01 - NURSING HOME** B. WING _____	**09/05/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	**900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542**

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K 056	Continued From page 5 NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5. This deficient practice could allow the a fire to progress cutting of escape for all 50 the residents, staff and visitors of the facility. Findings include: Observations during the facility tour on September 5, 2013, between 9:45 am to 11:30 pm, by surveyor 03006, revealed that the south entrance vestibule is not sprinkler protected. The Director of Maintenance verified this finding during the facility tour and with the Administrator during the exit conference.	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 3108

September 27, 2013

Mr. Kevin Gish, Administrator
First Care Living Center
900 Hilligoss Boulevard Southeast
Fosston, Minnesota 56542

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5512023

Dear Mr. Gish:

The above facility was surveyed on September 3, 2013 through September 6, 2013 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (612) 201-4124
Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00461	A. BUILDING: _____ B. WING _____	09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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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: On September 3, 4, 5, and 6, 2013, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." 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.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the	2 555		

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2 555	Continued From page 2 attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care (POC) for 1 of 1 resident (R24) to include the monitoring of a dialysis access port. In addition, the facility failed to develop a POC to include identified interventions for repositioning for 2 of 4 residents (R15, R38) identified at risk for pressure ulcers. Findings include: R24 lacked a comprehensive POC to address the monitoring of a dialysis access port. R24 was diagnosed with diabetes, heart disease and end stage renal failure. The quarterly Minimum Data Set (MDS) dated 6/4/13, indicated R24 had no cognitive deficits and was independent in transfers, ambulation and mobility. R24's POC dated 6/12/13, indicated R24 had dialysis three times a week due to end stage renal disease. The POC indicated R24 received a renal diet and was on 1000 - 1500 fluid restriction and directed staff to monitor weight and oral intake weekly, provide sufficient fluids thru meals and snacks and also to provide education. The POC also indicated no medications or solutions could be given via the dialysis access port unless approved by nephrologist and lab draws should	2 555		

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2 555	Continued From page 3	2 555		

never occur in an extremity containing a dialysis port. The POC directed staff to monitor R24's blood pressure prior to dialysis, however, it failed to direct staff not to take the blood pressure on the same arm the dialysis site was. The POC also failed to identify who was responsible for monitoring the site or how often the access site was to be monitored or what interventions were in place if the access site started to bleed.

The facility's North nurse's station had a Nursing Home Plan of Care for Hemodialysis Patients developed and supplied by R24's dialysis provider which directed staff to never to take blood pressure on the extremity that contains a dialysis access. This plan of care also noted the protection of a patients access was critical to their health and well-being on hemodialysis and directed facility staff to perform a daily check of the extremity access. This daily check included feeling for a pulsation in the access, listening for a bruit via stethoscope in the access and assessing for redness, warmth or signs of infection. The plan of care indicated the access dressing and bandages may be removed with 6-8 hours following dialysis and if there was bleeding and if staff were unable to stop the bleeding, directed them to notify the dialysis unit or nephrologist for further instructions.

On 9/6/13, 8:20 a.m. R24 was observed seated on the bed removing the dressing from the access site. R24 stated she would report any bleeding or signs of infections to the nurse. R24 also stated the nurses had not routinely checked the access site and sometimes would ask her ask about it.

On 9/6/13, at 7:03 a.m. registered nurse (RN)-B stated R24's access site was always covered with

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2 555	Continued From page 4	2 555		

a dressing when she returned from dialysis and the nurses did not do anything to the site. RN-B stated when the site was new there was something in the electronic medication administration record (e-mar) to do / sign off, but now they don't have to do anything. RN-B stated blood pressures were not to be taken in the arm of the access site and verified the POC lacked interventions related to monitoring the site or directing staff which arm to take blood pressure on.

On 9/6/13, at 10:15 a.m. the licensed practical nurse (LPN) and ward clerk verified it was not on the POC but stated it could be added. The LPN stated there used to be an order in the e-mar to check the access site daily but for some reason it was discontinued on 5/17/13.

The dialysis policy the facility provided was the Nursing Home Plan of Care for Hemodialysis Patients developed by the dialysis provider.

R15's POC dated 8/13/13, indicated R15 was at risk for the development of pressure ulcers and identified interventions such as pressure reducing mattresses on the bed and wheelchair. However, the POC did not direct the staff as to the frequency to which R15 was to be repositioned.

On 9/5/13, a 7:05 a.m. R15 was observed in the main lobby, seated in a wheelchair with a full body mechanical lift sling under him. At 7:50 a.m. R15 was assisted to the dining room for breakfast. At 8:24 a.m. R15 wheeled out of the dining room and down the hallway to the main lobby. While in the lobby R15 was observed to fall asleep while in the wheelchair without receiving assistance. At no time was R15 observed to be able to reposition himself in the wheelchair. At

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2 555	Continued From page 5 10:33 a.m. nursing assistant (NA)-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been repositioned since that time. NA-C and NA-A then assisted R15 to bed via a full body mechanical lift. R15's wheelchair was observed to be equipped with a pressure redistribution cushion. R15's skin was observed to be pink and intact free of pressure ulcers. At 10:40 a.m. NA-C confirmed R15 had not received assistance with repositioning between 6:30 am. and 10:33 p.m. a total of 4 hours and 3 minutes. On 9/5/14, at 12:35 p.m. registered nurse (RN)-A stated R15 was to receive assistance with repositioning every two hours and stated the POC should have been revised to direct the staff regarding the repositioning schedule. R38's diagnoses included a history of pressure ulcers (PU), arterial disease and peripheral vascular disease (PVD), a circulatory problem. R38's quarterly MDS indicated she had PU's and was at risk for the further development of PU's and required two staff extensive assistance for transfers and bed mobility. R38's current POC dated 8/28/13, indicated R38 was at risk for pressure ulcers and directed staff to assist with repositioning and offloading (pressure relief) every hour during awake hours, however, the POC lacked indication of the frequency R38 was to be turned and repositioned while in bed. On 9/5/13, R38 was observed continuously in bed on her back from 7:05 a.m. until 10:15 a.m.	2 555		

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2 555	Continued From page 6 At 10:15 a.m. NA-C stated R38 was placed on her back at 7:00 a.m. and verified R38 was to be turned in bed every 2 hours. At this time, R38 was turned to her left side to receive cares. (3 hours and 15 min without repositioning). At 1:02 p.m. RN-A verified R38 was at risk for PU's. RN-A stated R38 was to be repositioned every 2 hours while in bed. RN-A verified the repositioning schedule for R38 while in bed was not addressed on the POC. The Care Planning policy revised on 1/2009, directed staff to develop a comprehensive care plan for each resident. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized plans related to resident care. The Director of Nursing could randomly audit the care plan for the effectiveness of the care interventions TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
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.	2 565		

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2 565	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care (POC) for 1 of 4 residents (R15) who were observed for perineal care; the facility failed to provide ambulation services according to the POC for 1 of 1 resident (R13) reviewed for ambulation; the facility failed to provide incontinence care according to the POC for 3 of 3 residents (R38, R29, R15) reviewed for incontinence care. In addition, the facility failed to provide repositioning according to the POC for 2 of 5 residents (R38, R55) in the sample identified at risk for pressure ulcers. Findings include: INCONTINENCE CARE R38 was admitted on 9/12/12, with a pressure ulcer on her ankle and upper back. R38 also had arterial disease and peripheral vascular disease (PVD) a circulatory problem. R38's The current POC dated 7/3/13, directed staff to check R38's incontinent product every 2-3 hours during the day. On 9/5/13, from 7:05 a.m. until 10:09 a.m. R38 was continuously observed asleep on her back, in bed. At 10:09 a.m. nursing assistant (NA)-A and NA-C entered R38's room. Both verified there were assigned to R38's wing (South wing)	2 565		

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2 565	Continued From page 8 At 10:15 a.m. NA-C stated R38s brief was changed at 7 a.m. and R38 was incontinent of urine at that time. NA-C stated R38's brief was to be changed every 2 hours. At 10:20 a.m. NA-C changed R38's brief which was observed to be very wet. (3 hours and 20 minutes after the last brief change). At 1:02 p.m. registered nurse (RN)-A stated R38's incontinent product was to be changed every 2-3 hours during the day. RN-A verified the POC was not followed. REPOSITIONING On 9/5/13, at 1:02 p.m. RN-A verified R38 was at risk for PU's. RN-A stated R38 was to be offloaded hourly when up in the wheelchair. On 9/6/13, from 8:36 a.m. until 10:53 a.m. R38 was continuously observed seated in her wheelchair At 10:53 a.m. NA-B stated R38 was assisted into the wheelchair at 8:20 a.m. NA-B stated her and NA-A were the primary NAs for R38. NA-B verified R38 had not been repositioned since she was assisted into the wheelchair. NA-B confirmed R38 was to be repositioned every hour when in the wheelchair. At 10:55 a.m. NA-A and NA-B were observed to stand / offload R38. (2 hours and 35 minutes without repositioning). R55 was not repositioned as directed by the POC.	2 565		

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2 565	Continued From page 9 R55's POC dated 4/10/13, indicated R55 had a history of pressure ulcers and directed staff to assist R55 with repositioning every two hours and as needed. On 9/5/13, from 7:05 a.m. to 9:50 a.m. R55 was observed seated in her wheelchair without assistance with repositioning. At 9:50 a.m. NA-A and NA-C was observed to assist R55 to bed via a full body mechanical lift. R55's wheelchair was observed to be equipped with a pressure redistribution cushion. A skin protective dressing was observed to be intact over the left hip. On 9/5/13, at 10:00 a.m. NA-A confirmed R55 had been assisted out of bed at 7:00 a.m. and had not received assistance with repositioning since that time. A total of 2 hours and 50 minutes earlier. On 9/5/13, at 12:40 p.m. RN-A stated R55 was at risk for the development of pressure sores and was to repositioned every two hours as the POC directed Perineal and Incontinence cares: R15 did not receive assistance with perineal or incontinence cares as the POC directed for greater than 4 hours on the morning of 9/5/13. R15's POC dated 8/13/13, indicated R15 required total assistance of 1-2 staff for perineal cares and directed staff to provide incontinence cares every two hours. . On 9/5/13, a 7:05 a.m. R15 was observed seated in a wheelchair. At 7:50 a.m. R15 was assisted to the dining room for breakfast. At 8:24 a.m. R15 wheeled out of the dining room and down the	2 565		

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2 565	Continued From page 10 hallway to the main lobby. R15 was observed to fall asleep in the wheelchair while in the main lobby and without receiving assistance. At 10:33 a.m. NA-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been assisted with incontinence cares since that time. NA-C and NA-A then assisted R15 to bed via a full body mechanical lift. R15 was observed to be wearing an incontinence product which was saturated with urine. NA-A removed the saturated brief and applied a fresh brief. At no time was R15 observed to receive assistance with perineal cares. At 10:40 a.m. NA-C confirmed R15 had not received assistance with incontinence cares between 6:30 am. and 10:33 p.m. a total of 4 hours and 3 minutes. In addition NA-C confirmed R15 had not received perineal cares after having an incontinent episode. On 9/5/14, at 12:35 p.m. RN-A stated R15 was to received incontinence cares every two hours, and perineal cares after each incontinent episode as directed by the POC. Ambulation: R13's POC dated 8/28/13, directed two staff to assist R13 to a standing position and to use a four prong cane to assist R13 to ambulate up to 40 feet or more 2-3 times per week. On 9/4/13, at 4:03 p.m. R13 stated he used to walk all of the time, but had not walked as much because he required assistance with ambulation. Review of Ambulation Roster identified the following information.	2 565		

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	00461	A. BUILDING: _____ B. WING _____	09/06/2013

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2 565	Continued From page 11 The week of 6/8/13 - 6/14/13, R13 ambulated five times with distances carrying from 10 feet to 50 feet. The week of 6/15/13 - 6/21/13, R13 ambulated 20 feet two times. The week of 6/22/13- 6/28/13, R13 ambulated 10 feet on one occasion. The week of 6/29/13- 7/5/13, R13 ambulated 25 feet on one occasion. The week of 7/6/13 - 7/12/13, R13 ambulated 15 feet on one occasion. The week of 7/13/13 - 7/19/13, R13 did not ambulate. The week of 7/20/13 - 7/26/13, R13 did not ambulate. The week of 7/27/13 - 8/3/13, R13 ambulated 35 feet on once occasion. The week of 8/4/13- 8/10/13, R13 ambulated 3 times with distances varying from 10 feet to 100 feet. the week of 8/11/13- 8/17/13, R13 ambulated 13 feet one time. The week of 8/18/13 - 8/24/13, R13 ambulated 100 feet one time. The week of 8/25/13 - 8/31/13, R13 ambulated 3 times with distances varying from 50 feet to 200 feet. The week of 9/1/13- 9/6/13, R13 ambulated 3 times with distance varying from 55 feet to 125 feet. On 9/6/13, at 8:10 a.m. R13 was observed to ambulate with restorative nursing assistant (RNA)-A and NA-C with licensed practical nurse (LPN)-C following with the wheelchair. R13 was able to ambulate 100 feet with assistance. On 9/6/13, at 10:00 a.m. RN-C confirmed R13 had not consistently received assistance to	2 565		

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2 565	Continued From page 12 ambulate as the POC directed. Incontinence cares and repositioning: R29 did not receive timely assistance with incontinence cares and repositioning on the morning of 9/5/13, as directed by the POC. R29's POC dated 7/17/13, directed staff to assist with incontinence cares and repositioning every two hours. On 9/5/13, at 7:10 a.m. R29 was observed in bed on his back. R29 was observed to remain on his back until 9:10 a.m. at which time NA-A and NA-C were observed to provide R29 with morning cares. R29 was observed to be incontinent of bladder with intact skin. On 9/5/13, at 9:40 a.m. NA-C stated R29 had been last assisted with incontinence cares at 6:00 a.m. a total of 3 hours and ten minutes earlier. On 9/5/13, at 1:00 p.m. RN-A stated R29 was to receive assistance with incontinence cares and repositioning every two hours as directed by the POC. The Care Planning policy revised on 1/09, directed staff to follow the plan of care to ensure safety for the resident, staff members and facility. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing	2 565		

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2 565	Continued From page 13 care as directed by the written plan of care. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 590	MN Rule 4658.0435 Subp. 1 Confidentiality of Clinical Records and Info Subpart 1. Maintaining confidentiality of records. Information in the clinical records, regardless of form or storage methods, must be kept confidential according to Minnesota Statutes, chapter 13 and sections 144.335 and 144.651, and federal regulations. A resident's clinical information in a nursing home must be considered confidential but it must be made available to all persons in the nursing home who are responsible for the care of the resident. The clinical information must be open to inspection by representatives of the Department of Health and others legally authorized to obtain access. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure private dietary information was not accessible to the public for 23 residents (R50, R19, R13, R29, R26, R33, R68, R59, R37, R38, R56, R34, R66, R15, R27, R55, R11, R42, R3, R1, R51, R43, R20, R67) in the South dining room and for 24 residents (R24, R40, R41, R58, R5, R21, R69, R65, R46, R6, R57, R44, R31, R16, R48, R36, R39, R8, R2,	2 590		

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2 590	Continued From page 14 R70, R45, R23, R52) in the North dining room. Findings include: On 9/3/13, at 4:30 p.m. a dining observation was done in the the South dining room. Residents' were observed seated at the tables, with yellow dietary cards on a stand placed in front of each resident. The dietary card included the resident's first and last name and their diet according to the physician's order. This information was visible to anyone entering the dining room. The South dining room dietary cards read: R50-regular diet, texture as tolerated, nectar thick liquids at breakfast, thin liquids rest of day. R19, R13, R33, R15, R43, R51, R3, R42, R11 and R67 all had regular diets. R29-mechanical soft diet with nectar thick liquids. R26-mechanical soft diet with thin liquids, may have nectar liquids if coughing more than 3 spells a meal. R68 and R59 both had regular low sodium diets. R37 and R27 both had mechanical soft diets with regular liquids. R38-regular diet, small portions. R56-regular low sodium, low fat diet. R34-mechanical soft food, ground meat and regular liquids. R66-regular diet, no added salt. R55-mechanical soft diet with pureed meat. R1-pureed diet with honey thick liquids. R20-low salt diet. On 9/4/13, at 8:57 a.m. a dining observation was done in the the South dining room. The same yellow dietary cards which displayed personal resident information were observed on a stand placed in front of each resident.	2 590		

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2 590	Continued From page 15 On 9/5/13, at 7:57 a.m. a dining observation was done in the the South dining room. There same yellow dietary cards were observed on a stand placed in front of each resident. On 9/5/13, at 12:13 p.m. the nutrition services manager (NSM), verified the dietary cards included the residents' diet order. The NSM stated there was a list in the dining room cupboard that identified the residents' diet order. She stated staff could just look inside the cupboard for the information. The NSM stated she had been speaking with registered nurse (RN)-D recently about the dietary cards, and questioned whether it was a privacy issue. The NSM also verified the residents in the North dining room were also using the dietary cards with their name and diet order listed. The North dining room dietary cards read: R69, R6, R57, R44, R36, R48, R2, R70, R67, R16, R45, and R52 all had regular diets R24-renal diet, low potassium, 1400 ml fluid restriction. R40-ground meat texture, lactose free diet. R41-regular texture with no mixed textures, nectar thick liquids. R58-mechanical soft foods. R5-regular diet with small portions. R21-mechanical soft diet with ground meat. R65-low fat, low sodium diet. R46-low potassium diet. R31-pureed lactose free diet with honey thick liquids. R39-regular 3-4 carbohydrates, no concentrated sweets diet. R8-pureed diet with regular liquids. R23-regular low sodium diet with ground meat.	2 590		

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2 590	Continued From page 16 The PRIVACY NOTICE POLICY & PROCEDURE dated 4/03, indicated residents would receive a copy of the Privacy Notice that would explain how their protected health information would be used. The policy further indicated employees, staff and other personnel can access the resident's information. SUGGESTED METHOD FOR CORRECTION: The nutrition services manager could remove resident dietary information from the dietary cards. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 590		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure sufficient qualified nursing staff were available to meet the residents' needs for	2 800		

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2 800	Continued From page 17 nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 47 residents residing in the facility. Findings include: During the survey conducted on 9/3/13 thru 9/6/13, staff were observed to not be able to consistently provide services for the residents as directed by their plans of care based on a comprehensive assessment of their needs. The facility failed to provide timely meals in a manner which promoted dignity for 3 of 3 residents (R13, R29, R15) in the sample who did not receive breakfast. See F241. The facility failed to provide ambulation services according to the assessed need for 1 of 1 resident (13) in the sample. See F311. The facility failed to provide assistance with oral cares for 1 of 1 resident (R29) in the sample who were dependent on staff for oral hygiene. In addition, the facility failed to provide perineal care for 1 of 3 residents (R15) reviewed for incontinence care. See F312. The facility failed to ensure a resident identified at risk for pressure ulcers (PU) received timely repositioning for 4 of 5 residents (R38, R15, R55 and R29) in the sample identified at risk for pressure ulcers. See F314. The facility failed to ensure residents identified at risk for urinary incontinence received timely assistance for 3 of 4 residents (R38, R15 and R29) in the sample identified as incontinent	2 800		

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2 800	Continued From page 18 based on the comprehensive assessment. See F315. Staffing reports were reviewed for the previous five weeks. (8/1/13 - 9/6/13) and the projected two weeks (9/6/13 - 9/22/13). The facility staffing pattern determined the day shift required two nursing assistants (NA), two nursing assistants to work as NA and as a universal workers, two NAs to complete restorative exercises and one NA designated to assist residents with baths. Two licensed nurses routinely did medication administration, documentation, and other non-direct care nursing duties, but were available to assist NAs with the care of residents if deemed necessary. The evening shift staffing pattern consisted of five NAs to work an eight hour shift and one NA to work a five hour shift along with two licensed staff. The night shift consisted of one licensed staff and two NA's. The staffing report for August 2013, identified 31 days of which 12 days were without shortages and 20 days (8/1, 2, 3, 4, 5, 7, 8, 9, 11, 16, 17, 20, 22, 23, 25, 26, 27, 29, 30, 31) nursing assistant staff had shortages of 1 - 3 staff members. In September from 9/1/13 - 9/6/13, the facility had daily staffing shortages of 1-3 staff. Of the projected nursing schedule from 9/7/13 - 9/22/13, the facility had six days (9/9, 12, 14, 15, 17, 18) in which the nursing staff were to work with 1 -2 nursing assistants short. On 9/3/13, at 4:15 p.m. R59 an alert and oriented resident, reported the facility was frequently short staffed in the morning. R59 explained he would	2 800		

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2 800	Continued From page 19 like to get up around 6:30 a.m. but the facility did not seem to have enough staff to help him. On 9/3/13, at 5:38 p.m. R47, an alert and oriented resident stated it took a long time for the staff to answer lights in the morning, but felt that was part of living in a nursing home. On 9/5/13, at 7:00 a.m. the facility was staffed with five nursing assistants instead of seven and two medication nurses. As support staff arrived at the facility, licensed practical nurse (LPN)-A assisted in the dining room. Registered nurse (RN)-A, LPN-D/social service designee, and the director of nurses (DON) were not observed to assist the NAs who were providing direct care. On 9/5/13, at 12:04 p.m. NA-C stated she the facility was short a nursing assistant and she was running behind. She stated when the support staff such as the registered nurses doing paper work, the licensed practical nurses (LPN) who worked as the social service designee and the ward clerk and the director of nurses arrived at the facility, they did not check in with the staff on the floor to see how things were going. NA-C stated they may check in with the wing nurses and LPN-A assists with the dining room, but they do not routinely assist with providing cares on the floor. NA-C stated the facility was frequently short staffed. NA-C added she and NA-A had 22 residents assigned to them to provide morning cares to. Of those 22 residents,13 of the residents required assistance of two staff for some or all of the morning cares and only two residents were completely independent with their morning routine. On 9/5/13, at 12:11 p.m. NA-A stated the facility has been short staffed for the past few weeks.	2 800		

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2 800	Continued From page 20 He stated the nursing staff will help when they can but they do not consistently ask if the NA's on the floor need help. On 9/5/13, at 12:20 p.m. LPN-A stated each morning she assists the residents in the north dining room and will help the staff whenever she had a chance. She stated she was aware at 7:30 a.m. that the staff on the floor were two nursing assistants short, but she was unable to help due to meeting. On 9/5/13, at 12:44 p.m. RN-A stated she had arrived at the facility at 8:40 a.m. and had been made aware the facility was two NA's short. She stated on a regular day she would be informed about such concerns around 10:00 a.m. during morning report. She stated she could easily help the staff on the floor but had not been asked to assist. She stated she was unable to assist the morning of 9/5/13, because of a meeting. She stated the facility had occasional short staffing patterns and the charge nurses called as many staff as they could to try to find assistance to cover the shift. On 9/5/13, at 1:00 p.m. LPN-C who was working the south cart stated the LPN's try to help the NAs on the floor as much as possible. She stated LPN-A usually helped with meals, but the other licensed did not consistently help unless asked. On 9/5/13, at 1:15 p.m. a nursing staff member who requested to remain anonymous stated the facility was short staffed quite frequently. The staff member explained that in the past week, the facility had 17 shifts which were not filled, one death, one planned discharge and five new admissions. The staff member stated the support licensed staff (LPN-A, LPN-D/SSD, RN's and	2 800		

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2 800	Continued From page 21 DON) may check in with the charge nurses, but they do not assist with cares. The staff stated LPN-A would assist with meals. On 9/6/13, at 7:16 a.m. NA-A stated the facility had four NA's, a bath aide and a float (total of six). The facility was short one nursing assistant. On 9/6/13, at 7:43 a.m. restorative aide (RA)-A stated she ended up working the floor as a nursing assistant 2-3 days a week to provide direct care for the residents. She stated she was not consistently able to complete restorative cares because of providing direct care support. During an interview with the DON on 9/6/13, at 8:25 a.m. the DON explained each morning she and LPN-A reviewed the staffing patterns. She stated the facility was currently going through a difficult transition due to employee illness and some staffing changes. She explained LPN-A and the DON did not leave the facility "short short." When questioned as to the definition of short short, the DON did not respond. She explained based on the statistical findings, the facility was still meeting the needs of the residents. When questioned if the current residents were receiving cares, she stated she was unaware of any concerns. The DON confirmed in the past seven days, the facility had one planned discharge, one death and four new admissions. Upon review of the staffing pattern, the DON confirmed the facility was not currently meeting the established staffing pattern. On 9/6/13, at 10:40 a.m. LPN-D stated she assisted the staff on the floor when possible and assisted with filling the open shifts. She stated all of the staff assist with picking up shift and according to the statistical findings, the facility	2 800		

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2 800	Continued From page 22 was meeting the required staffing ratios. A policy regarding sufficient staff was requested, but not provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing could provide education for all staff to ensure that residents receive care and their needs are met. The director of nursing could revise the workloads of staff to accommodate each resident's needs. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced	2 830		

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2 830	Continued From page 23 by: Based on observation, interview and document review, the facility failed to ensure an enabler bar was safe to use for 2 of 2 residents (R38, R42) in the sample. In addition, the facility failed to ensure enabler bars were assessed for resident safety which had the potential to affect 17 residents (R38, R42, R37, R56, R33, R20, R59, R13, R26, R48, R23, R58, R44, R57, R6, R52, R2) who utilized enabler bars. Findings include: R38 was diagnosed with arterial disease and peripheral vascular disease (PVD, a circulatory problem). The quarterly Minimum Data Set (MDS) dated 6/25/13, indicated R38 was cognitively intact and required extensive assistance of two staff for bed mobility and transfers. R38's plan of care (POC) dated 7/3/13, indicated R38 used enabler bars on the bed to increase her bed mobility. On 9/4/13, at 9:59 a.m. bilateral enabler bars were observed on R38's bed. In the center of the rail a horizontal PVC pipe (a combination pipe made from plastic and vinyl) was observed which ran left to right on the bar. The PVC pipe had 2 screws on the end of the enabler bar that were sharp to the touch. R38 stated the rails were sharp and stated a couple of times she had sustained skin tears from the rails. An undated incident report indicated a nursing assistant (NA) observed a skin tear on R38s right upper arm covered with dried blood. After cleansing, it was noted there were three separate	2 830		

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2 830	Continued From page 24 tears in a row with the one closest to the elbow which measured 1.0 centimeter (cm), next 0.5 cm and at the top there was a "V"-shaped tear measuring 0.75 cm on each side of the "V." On 8/9/13, the nursing progress notes indicated a NA had observed a skin tear on R38's upper outer arm. Had dried blood over the area and was difficult to cleanse adequately due to fragile skin. The note indicated the NA had asked R38 how this had occurred and the resident stated she had bumped her arm on her enabler bar during the previous night. The note also indicated there were three tears in a line. This was documented by licensed practical nurse (LPN)-D. On 9/6/13, at 9:47 a.m. LPN-B verified the 8/9/13, incident report was undated when printed. LPN-B stated the entry for the incident report was date stamped on the computer. LPN-B then printed the corresponding nursing progress note. On 9/6/13 at 10:10 a.m. the director of nursing (DON), stated she had not realized R38's skin tears were from the enabler bar. The DON stated LPN-D had not documented on the incident report the skin tears were from the enabler bar and stated she would have had to read the nurses notes to know it was from the enabler bar. On 9/6/13, at 10:32 a.m. the social service designee (SSD) stated she had spoken with R38 after the incident and R38 had told the SSD she had been bumped on the enabler bar . R42's diagnoses included explosive personality disorder and depression. The quarterly MDS dated 8/6/13, indicated R42 had moderate cognitive impairment and required extensive assistance with activities of daily living including	2 830		

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2 830	Continued From page 25 bed mobility. The Pressure Ulcer Care Area Assessment (CAA) dated 5/22/13, indicated R42 utilized enable bars on the bed to assist in turning and repositioning. The CAA also indicated R42 was was able to turn from side to side in the bed independently and required extensive assistance to go from a supine to sitting position. R42's POC dated 2/27/13, indicated R42 utilized bilateral enable bars to aid with turning repositioning and bed mobility and to aide in independence. The Alternative Device form dated 4/26/13, identified R42 as having enabler bars in place. The reason for the bars and the date which they were placed was not identified on the form. The form stated the bars were in place prior to the implementation of the Alternative Device form which was started on 4/26/13. On 9/3/13, at 6:10 p.m. R42's bed was observed to be equipped with two large "U" shaped enabler bars. The bars were observed to have been adapted with one PVC pipe that ran from left to right on the bar. The space which the PVC pipe created between the pipe and the bed frame was large. The edges of the pipe were held in place with screws which were sharp to the touch and the edges of the pipe were not secure to the inner aspect the bar causing it to move up and down, exposing rough edges of the pipe. On 9/5/13, at 2:15 p.m. RN-A stated the maintenance department had visualized the enabler bars to ensure appropriate size for resident use. RN-A stated she was aware R42 used his bars for bed mobility, but at no time did the facility complete assessments on the bars to	2 830		

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2 830	Continued From page 26 ensure they were safe for the residents. At 2:30 p.m. RN-A measured the spaces between the PVC pipe and the bed frame. RN-C reported the space was greater than 8.0 inches. RN-C verified the tape around the main U shape on the right bar was peeling away and that the screws and edges of the PVC pipe were rough and residents could potentially become injured. The Federal Food and Drug Administration (FDA) Hospital Bed System Dimensional and Assessment guidance to Reduce Entrapment dated 3/10/06, indicated the space between the bed rails was not to exceed 4 3/4 inches. On 9/6/13, at 9:20 a.m. maintenance staff member (MS)-A stated when ordered by the facility, the enabler bars were large U shaped bars with no additional bars in them to decrease the space between the rails. He explained the facility staff members had added two PVC pipes to each of the rails to ensure the space between the rails did not exceed 4 3/4 inches. He stated he was unaware why R42's rails only had one PVC pipe. He stated it should have two PVC pipes. On 9/6/13, at 9:30 a.m. the director of environmental services (DES) stated the facility had purchased several rails about seven years ago. The DES stated the facility had required more rails over the years therefore, some of the maintenance staff had fabricated matching rails. He explained the PVC pipes had been added to all of the rails to decrease the spaces for potential entrapment. He stated all of the rails with a singe PVC pipe should have been removed and they should all be equipped with two PVC pipes. He stated the facility did not have any manufacture documentation regarding the rails and stated all	2 830		

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2 830	Continued From page 27 of the original manufactured rails had been altered in an attempt to reduce the rails. The DES added the facility was currently in the process of reviewing new bed options which were equipped with enabler bars and they had received approval for them. However, they were not currently in house and alternative enabler bars were not available. On 9/6/13, at 12:00 p.m. licensed practical nurse (LPN)-A provided a list which identified the facility currently had 17 resident beds equipped with enabler bars which had either been altered from the manufacturer's original design or fabricated by staff. The list indicated R38, R42, R37, R56, R33, R20, R59, R13, R26, R48, R23, R58, R44, R57, R6, R52, and R2 all had altered rails on their beds. The 1/2 side Rail/Enabler Use in LTC (long term care) policy dated 7/11, directed the staff to assess the resident upon admission for the use of 1/2 side rails/enablers. The policy did not direct the staff to ensure the rails were safe for the residents. SUGGESTED METHOD FOR CORRECTION: The environmental director could assess the safety of each enabler bar in the facility. The environmental director would remove any unsafe bars and apply enabler bars according to manufacturer's recommendations. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 905	Continued From page 28	2 905		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident identified at risk for pressure ulcers (PU) received timely repositioning for 4 of 5 residents (R38, R15, R55 and R29) in the sample identified at risk for pressure ulcers. Findings include: R38 was at risk for pressure ulcers and did not recieve turning and repositioning assistance for three hours and 15 minutes on 9/5/13, and two hours and 35 minutes on 9/6/13. R38 was admitted on 9/12/12, with a PU on her ankle and upper back. R38 also had arterial disease and peripheral vascular disease (PVD, a circulatory problem). The Assessment of Pressure Sore Potential dated 6/20/13, indicated R38 was at risk for PU development. The quarterly Minimum Data Set (MDS) dated 6/25/13, indicated R38 was cognitively intact,	2 905		

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2 905	Continued From page 29 required two staff extensive assistance for repositioning and had two stage one PU's. The PU Care Area Assessment (CAA) dated 9/5/13, indicated R38 was admitted with PUs. R38's plan of care (POC) dated 8/28/13, indicated R38 was at risk for pressure ulcers and directed staff to assist with repositioning and offloading (presure relief) hourly during awake hours. The POC lacked indication of R38's repositioning needs when in bed. On 9/4/13, at 10:01 a.m. R38 stated she did get tired from sitting in her wheelchair. On 9/5/13, at 7:05 a.m. R38 was observed asleep on her back in bed. R38 was continuously observed in bed, on her back until 8:37 a.m. - At 8:37 a.m. R38 was observed awake and remained on her back in bed. R38 was continuously observed in bed,on her back until 9:47 a.m. - At 9:47 a.m. R38 was awake on her back in bed. R38 stated she was still waiting to get up. R38 asked, "What takes them so long?" R38 was observed continuously on her back until 10:09 a.m. - At 10:09 a.m. nursing assistant (NA)-A and NA-C entered R38's room. - At 10:11 a.m. NA-C stated her and NA-A were the NAs assigned to the South wing. - At 10:15 a.m. NA-C stated R38 was placed on her back at 7:00 a.m. and was to be turned in bed every 2 hours. At this time, R38 was turned to her left side to receive cares. (3 hours and 15 min without repositioning). - At 10:17 a.m. R38 asked NA-A, "Why are you so late?" - At 1:02 p.m. registered nurse (RN)-A stated R38 was identified at risk for PU. RN-A stated R38	2 905		

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2 905	Continued From page 30 was to be offloaded hourly when up in the wheelchair, and every two hours while in the bed. RN-A verified the repositioning schedule for R38 while in bed was not addressed on the care plan. On 9/6/13, at 8:36 a.m. R38 was observed in her wheelchair at the breakfast table. R38 was continuously observed until 9:27 a.m. - At 9:27 a.m. the social service designee brought R38 to her room. - At 9:35 a.m. R38 was observed to remain up in her wheelchair in her room. - At 9:38 a.m. activity aide (AA)-A brought R38 to exercise group in the lobby. R38 was continuously observed until 10:50 a.m. - At 10:50 a.m. R38 stated her bottom was sore from sitting. - At 10:53 a.m. NA-B stated R38 was assisted into the wheelchair at 8:20 a.m. NA-B stated R38 had not been repositioned since she was placed in the wheelchair. NA-B stated R38 was to be repositioned every hour in the wheelchair. - At 10:55 a.m. R38 was observed to be stand with NA-A and NA-B's assistance for repositioning / offloading. (2 hours and 35 minutes without repositioning). - At 11:00 a.m. NA-B stated the lack of repositioning occurred due to understaffing. R15 did not receive assistance with repositioning for greater than four hours on the morning of 9/5/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive impairments and required extensive assistance with activities of daily living. The MDS also indicated R15 was at risk for the development of PUs.	2 905		

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2 905	Continued From page 31 The PU CAA dated 8/13/13, indicated R15 was at risk for the development of PU's due to urinary incontinence and decreased mobility. The Assessment of Pressure Sore Potential form dated 8/6/13, identified R15 at moderate risk for the development of PUs. The Tissue Tolerance Assessment dated 8/6/13, indicated R15 was able to sit for two hours without redness noted on his skin. R15's POC dated 8/13/13, indicated R15 was at risk for the development of PUs and identified interventions such as pressure reducing mattresses on the bed and wheelchair. However, the POC did not direct the staff as to the frequency to which R15 was to be repositioned. On 9/5/13, a 7:05 a.m. R15 was observed seated in a wheelchair in the main lobby. - At 7:50 a.m. R15 was assisted to the dining room for breakfast. - At 8:24 a.m. R15 wheeled out of the dining room and down the hallway to the main lobby. R15 was observed to fall asleep in the wheelchair while in the main lobby without receiving assistance. At no time was R15 observed to be able to reposition himself in the wheelchair. On 9/5/13, at 10:00 a.m. NA-A stated R15 had not received assistance with repositioning since being assisted out of bed. - At 10:33 a.m. NA-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been repositioned since that time. NA-C and NA-A then assisted R15 to bed via a full body mechanical lift. R15's wheelchair was observed to be equipped with a	2 905		

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2 905	Continued From page 32 pressure redistribution cushion. R15's skin was observed to be pink and intact free of pressure ulcers. - At 10:40 a.m. NA-C confirmed R15 had not received assistance with repositioning between 6:30 a.m. and 10:33 p.m. a total of 4 hours and 3 minutes. On 9/5/14, at 12:35 p.m. registered nurse (RN)-A stated R15 was to receive assistance with repositioning every two hours. R55 did not receive timely assistance with repositioning and had a history of PUs. R55's diagnoses included Alzheimer's disease, a stroke and dementia. The quarterly MDS dated 6/25/13, indicated R55 had severe cognitive impairment and required extensive assistance with bed mobility, total assistance with transfers and as being non ambulatory. The assessment also indicated R55 was at risk for the development of pressure ulcers. The PU CAA dated 4/9/13, indicated R55 was at risk for the development of pressure ulcers due to decreased mobility and cognitive impairment. The Assessment of Pressure Sore Potential form dated 6/21/13, indicated R55 was at risk for the development of PUs. The Tissue Tolerance Assessment form dated 6/21/13, indicated R55 had the ability to sit for up to two hours without the development of redness on her skin. The Skin Risk Assessment and Interventions form dated 6/21/13, indicated R55 had a history	2 905		

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2 905	Continued From page 33 of PUs and required staff to assist with repositioning every two hours. R55's POC dated 4/10/13, identified R55 as having a history of PUs. The POC directed staff to assist R55 with repositioning every two hours and as needed. The nurses note dated 8/24/13, indicated the nursing staff had identified two open areas on the left hip. The first area was approximately 2 cm (centimeters) and red in color. The second area was a 0.75 cm dry open area in the middle of the first area. The nursing staff applied a Exuderm dressing (thin protective dressing) over the area and planned to monitor until the area had resolved. On 9/5/13, at 7:05 a.m. R55 was observed in the main lobby, seated in a wheelchair. A full body mechanical lift sheet was positioned under the resident. - At 7:35 a.m. R55 was observed to be assisted to her room by a laboratory staff member. - At 7:45 a.m. R55 was returned to the lobby area. - At 7:55 a.m. R55 was assisted to the South dining room for breakfast. - At 8:32 a.m. R55 was wheeled from the dining room to the main lobby area. R55 remained in the lobby area until 9:50 a.m. at which time NA-A and NA-C assisted R55 to bed via a full body mechanical lift. R55's wheelchair was observed to be equipped with a pressure redistribution cushion. A protective dressing was observed to be intact over the left hip. On 9/5/13, at 10:00 a.m. NA-A confirmed R55 had been assisted out of bed at 7:00 a.m. and had not received assistance with repositioning	2 905		

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2 905	Continued From page 34 since that time. A total of two hours and 50 minutes earlier. On 9/5/13, at 12:40 p.m. RN-A stated R55 was at risk for the development of pressure sores and was to be repositioned every two hours. At 2:50 p.m. RN-A observed R55's left hip and identified the protective dressing on the left hip. RN-A refused to remove the dressing to assess R55's skin at that time. On 9/6/13, at 12:30 p.m. the DON reported the dressing from the left hip had been removed and the open area had resolved. R29 was identified at risk for the development of PUs and was not provided timely assistance with repositioning on the morning of 9/5/13, for three hours and 11 minutes. R29's diagnoses included anxiety, dementia with behavioral disturbances and paranoia. The quarterly MDS dated 7/9/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living, including extensive assistance with bed mobility and total assistance with transfers. The MDS also indicated R29 was at risk for the development of PUs. The PU CAA dated 4/21/13, also identified R29 at risk for the development of PUs. R29's POC dated 7/17/13, indicated R29 was at risk for skin breakdown and directed staff to assist with repositioning every two hours. The Assessment of Pressure Sore Potential form dated 7/8/13, identified R29 as being at high risk for the development of PUs.	2 905		

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2 905	Continued From page 35 The Skin Risk Assessment and Interventions form dated 7/8/13, identified R29 at high risk for the development of PU and directed staff to assist with repositioning every two hours while sitting or supine. On 9/5/13, at 7:10 a. R29 was observed resting in bed on his back. R29 was observed to remain in bed, on his back until 9:10 a.m. at which time R29 was observed to receive assistance with morning cares. R29's skin was observed to be intact. At 9:20 a.m. R29 was transferred from the bed via a full body mechanical lift with the assistance of NA-A and NA-C. On 9/5/13, at 9:40 a.m. NA-C stated R29 had been last assisted with repositioning at 6:00 a.m. a total of 3 hours and ten minutes earlier. On 9/5/13, at 1:00 p.m. RN-A stated R29 was to receive assistance with repositioning every two hours as directed by the POC. The Skin Assessment policy revised on 8/06, and the Repositioning policy revised on 6/2011, directed the staff to provide assistance with repositioning as directed by the resident's individual assessment. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review policy and procedures related to providing repositioning cares to residents at risk of developing pressure ulcers. The DON could educate staff on pressure ulcer protocols and develop a monitoring system to ensure compliance. The Quality Assessment and Assurance (QAA) committee could do	2 905		

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	00461	A. BUILDING: _____ B. WING _____	09/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

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2 905	Continued From page 36 random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents identified at risk for urinary incontinence received timely assistance with toileting and incontinence care for 3 of 4 residents (R38, R15 and R29) in the sample identified as incontinent based on the comprehensive assessment. Findings include:	2 910		

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2 910	Continued From page 37 R38 was incontinent of urine and did not receive incontinence care as directed by the plan of care (POC). R38's diagnoses included a history of pressure ulcers, arterial disease and peripheral vascular disease (PVD, a circulatory problem). The quarterly Minimum Data Set (MDS) dated 6/25/13, indicated R38 was cognitively intact. The bladder assessment dated 6/25/13, indicated R38 refused a toileting program and staff continued to change incontinent brief per manufacturer's recommendations. The Urinary Incontinence Care Area Assessment (CAA) dated 9/5/13, indicated R38 had episodes of bladder incontinence. R38's POC dated 7/3/13, directed staff to provide incontinent cares every 2-3 hours during the day. On 9/5/13, at 7:05 a.m. R38 was observed asleep on her back in bed. R38 was continuously observed in bed, on her back until 10:09 a.m. - At 10:09 a.m. nursing assistant (NA)-A and NA-C entered R38's room. - At 10:11 a.m. NA-C stated her and NA-A were the NAs assigned to the South wing. - At 10:15 a.m. NA-C stated R38's brief was changed at 7 a.m. and R38 was incontinent of urine at that time. NA-C stated the R38's incontinent brief was to be changed every 2 hours. - At 10:20 a.m. NA-C changed the brief and R38's incontinent product was observed saturated with urine. (3 hours and 20 minutes after the last brief change). On 9/5/13, at 1:02 p.m. registered nurse (RN)-A	2 910		

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2 910	Continued From page 38 stated R38 was to receive incontinence cares every 2-3 hours during the day. RN-A verified the POC was not followed. R15 did not receive assistance with incontinence cares for greater than four hours on the morning of 9/5/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive impairment and required extensive assistance with activities of daily living. The MDS also indicated R15 was frequently incontinent of bowel and bladder. The Urinary Incontinence CAA dated 8/13/13, indicated R15 was frequently incontinent of bowel and bladder and directed staff to assist with incontinence cares every two hours. The B & B H& P (Bowel and Bladder History and Physical) Assessment dated 8/6/13, indicated R15 was incontinent of bowel and bladder and required extensive assistance of two staff to use the toilet. It directed the staff to assist R15 with incontinence cares every two hours. R15's POC dated 8/13/13, directed staff to assist with incontinence cares every two hours. On 9/5/13, a 7:05 a.m. R15 was observed in the main lobby seated in a wheelchair. - At 7:50 a.m. R15 was observed to be assisted to the dining room for breakfast. - At 8:24 a.m. R15 wheeled out of the dining room and down the hallway to the main lobby. R15 was observed to fall asleep in the wheelchair while in the main lobby without receiving assistance.	2 910		

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2 910	Continued From page 39 On 9/5/13, at 10:00 a.m. NA-A stated R15 had not received assistance with incontinence since he got out of bed before breakfast. At 10:33 a.m. NA-C stated other staff members had assisted R15 out of bed around 6:30 a.m. She confirmed R15 had not been assisted with incontinence cares since that time. NA-C and NA-A were then observed to assist R15 to bed via a full body mechanical lift. R15 was observed to be wearing an incontinence product which was saturated with urine. At 10:40 a.m. NA-C confirmed R15 had not received assistance with incontinence cares between 6:30 am. and 10:33 p.m. a total of four hours and three minutes. On 9/5/14, at 12:35 p.m. RN-A stated R15 was to receive incontinence cares every two hours as directed by the POC. R29 did not receive timely assistance with incontinence cares on the morning of 9/5/13. R29's diagnoses included anxiety, dementia with behavioral disturbances and paranoia. The quarterly MDS dated 7/9/13, indicated R29 had severe cognitive impairments and required extensive assistance with all activities of daily living. The MDS also identified R29 as being totally incontinent of bladder. The Urinary Incontinence CAA dated 4/21/13, identified R29 as being totally incontinent of bladder. R29's POC dated 7/17/13, directed staff to assist with incontinence cares every two hours. The B&B H&P assessment dated 7/8/13, identified R29 as being totally incontinent of bladder and required assistance of staff to	2 910		

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2 910	Continued From page 40 provide incontinence cares every two hours. On 9/5/13, at 7:10 a. R29 was observed resting in bed on his back. R29 was observed to remain in bed, on his back until 9:10 a.m. at which time R29 received assistance with morning cares from NA-A and NA-C. R29 was observed to be incontinent of bladder at the time of morning cares. On 9/5/13, at 9:40 a.m. NA-C stated R29 had been last assisted with incontinence cares at 6:00 a.m. a total of three hours and ten minutes earlier. On 9/5/13, at 1:00 p.m. RN-A stated R29 was to receive assistance with incontinence cares every two hours as directed by the POC. The Bladder and Bowel Assessment policy dated 12/05 and revised on 11/06 directed the staff if a resident was incontinent with no control present with the inability to retain, the resident was to receive assistance with having the incontinent product check every two hours and changed as needed. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could review policies and procedures to ensure residents receive appropriate toileting/incontinence care based on their assessed needs. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

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2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services according to the assessed need for 1 of 1 resident (R13) in the sample. Findings include: R13's diagnoses included muscle weakness, shortness of breath and peripheral vascular disease. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R13 was cognitively intact and required extensive assistance for bed mobility, transfer and ambulation. The Quarterly Review form dated 8/20/13,	2 915		

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2 915	Continued From page 42 indicated R13 was able to ambulate with assist of two staff using a gait belt and a four prong cane. The form also indicated R13 had occasionally became anxious when ambulating but with encouragement R13, was able to ambulate. R13's plan of care (POC) dated 8/28/13, directed two staff to assist him to a standing position and to use a four prong cane to assist R13 to ambulate up to 40 feet or more 2-3 times per week. On 9/4/13, at 4:03 p.m. R13 stated he used to walk all of the time, but he had not walked as much now because he required assistance with ambulation. Review of Ambulation Roster identified the following information: The week of 6/8/13 - 6/14/13, R13 ambulated five times with distances varying from 10 feet to 50 feet. The week of 6/15/13 - 6/21/13, R13 ambulated 20 feet two times. The week of 6/22/13- 6/28/13, R13 ambulated 10 feet on one occasion. The week of 6/29/13- 7/5/13, R13 ambulated 25 feet on one occasion. The week of 7/6/13 - 7/12/13, R13 ambulated 15 feet on one occasion. The week of 7/13/13 - 7/19/13, R13 did not ambulate. The week of 7/20/13 - 7/26/13, R13 did not ambulate. The week of 7/27/13 - 8/3/13, R13 ambulated 35 feet on once occasion. The week of 8/4/13- 8/10/13, R13 ambulated 3 times with distances varying from 10 feet to 100 feet.	2 915		

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2 915	Continued From page 43 The week of 8/11/13- 8/17/13, R13 ambulated 13 feet one time. The week of 8/18/13 - 8/24/13, R13 ambulated 100 feet one time. The week of 8/25/13 - 8/31/13, R13 ambulated 3 times with distances varying from 50 feet to 200 feet. The week of 9/1/13- 9/6/13, R13 ambulated 3 times with distance varying from 55 feet to 125 feet. The Ambulation Roster documented reasons why R13 had not ambulated were "unable," "not available," "refused" or "was able to stand for weight bearing." On 9/6/13, at 8:10 a.m. R13 was observed to ambulate with restorative nursing assistant (RNA)-A and nursing assistant (NA)-C with licensed practical nurse (LPN)-C following with the wheelchair. R13 was able to ambulate 100 feet with assistance. On 9/6/13, at 10:00 a.m. registered nurse (RN)-C stated R13 had occasionally refused to ambulate, but still had the ability to walk. RN-C stated due to low staffing patterns, the staff did not have the time to complete the ambulation programs. She confirmed R13 had not consistently received assistance to ambulate as directed by the POC. On 9/6/13, at 10:30 a.m. RNA-A stated the restorative programs had not been consistently implemented because of short staffing. She stated if the computer documentation was marked as refused, unavailable, or unable, it may have been due to the resident being physically unable to ambulate, or that the facility did not have a restorative nursing assistant that day. She stated when the documentation was completed,	2 915		

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2 915	Continued From page 44 the staff had not indicated any further explanation as to why the resident did not participate in the restorative program. She confirmed R13 had not received consistent implementation of the restorative program. The Walking Program, Direct Care Staff policy revised on 11/2002, directed the staff to provide assistance to ensure the resident maintain the highest level of range of motion and mobility as possible. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review policies and procedures to ensure residents receive ambulation services according to the care plan. The DON could train additional staff to ambulate residents. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 920		

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2 920	Continued From page 45 review, the facility failed to provide assistance with oral cares for 1 of 1 resident (R29) in the sample who was dependent on staff for oral hygiene. In addition, the facility failed to provide perineal care for 1 of 3 residents (R15) reviewed for incontinence care. Findings include: R29 did not receive assistance with oral care on the morning of 9/5/13. R29's diagnoses included dementia with behavioral disturbances, paranoid state and anxiety. The quarterly Minimum Data Set (MDS) dated 5/25/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living. The MDS did not identify any concerns with R29's teeth. Review of the clinical record did not contain any type of assessment related to R29's oral cavity or teeth. R29's plan of care (POC) dated 7/17/13, identified R29 as having upper and lower dentures and directed staff to assist with oral cares twice a day and as needed. On 9/5/13, from 9:00 a.m. to 9:30 a.m. nursing assistants (NA)-A and NA-C were observed to provide R29 total assistance with morning cares. R29's natural teeth were observed with multiple blackened areas with white matter build up between them. At 9:27 a.m. NA-C offered R29 a drink of water, but at no time was R29 offered an opportunity to brush his teeth. On 9/5/13, at 9:40 a.m. NA-C assisted R29 with	2 920		

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2 920	Continued From page 46 breakfast in the dining room. At 10:10 a.m. R29 was wheeled to the main lobby to participate in morning activities. At 10:15 a.m. NA-C confirmed R29 had his own teeth and oral cares had not been provided or offered during morning cares. On 9/5/13, at 12:50 p.m. registered nurse (RN)-A verified R29 was to receive assistance with oral cares each morning. She stated at no time when completing the MDS / assessment had she been instructed to physically look into R29's mouth. She stated she was unaware if R29 had dentures or natural teeth. On 9/6/13, at 8:10 a.m. the director of nursing (DON) asked NA-A what type of teeth R29 had. NA-A reported R29 may have a partial, but the majority of his teeth were natural. The DON confirmed R29's POC had not accurately reflected R29's current oral status and verified oral cares should have been completed. A policy regarding oral care was requested but not provided. R15 did not receive assistance with perineal cares after an incontinent episode on 9/5/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive impairment and required extensive assistance with activities of daily living. The MDS also indicated R15 was frequently incontinent of bowel and bladder. The Urinary Incontinence Care Area Assessment	2 920		

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2 920	Continued From page 47 (CAA) dated 8/13/13, indicated R15 was frequently incontinent of bowel and bladder and directed staff to assist with incontinence cares every two hours. The B & B H& P (Bowel and Bladder History and Physical) Assessment dated 8/6/13, identified R15 as being incontinent of bowel and bladder and required extensive assistance of two staff to use the toilet. The assessment directed staff to assist R15 with incontinence cares every two hours. R15's POC dated 8/13/13, directed staff to assist with incontinence cares every two hours and required extensive total assistance with pericares after each incontinent episode. On 9/4/13, at 10:33 a.m. NA-C and NA-A assisted R15 to bed via a full body mechanical lift. R15 was observed to be wearing an incontinence product which was observed saturated with urine. NA-A removed the soiled brief and applied a clean brief. At no time did the nursing assistants provide R15 with perineal care. At 10:40 a.m. NA-C confirmed R15 had not received assistance with perineal cares after being incontinent of urine. On 9/5/14, at 12:35 p.m. RN-A stated R15 was to receive perineal cares after each incontinent episode as directed by the POC. The Bladder and Bowel Assessment policy revised on 11/2006, included an undated manufacturer's guidelines which directed the staff to provide peri-care after removing a soiled incontinent product.	2 920		

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2 920	Continued From page 48 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review policies and procedures to ensure residents receive oral hygiene and perineal care according to the care plan. The DON could provide an in-service for the nursing staff to review oral hygiene and perineal care. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;	21390		

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21390	Continued From page 49 G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control technique was maintained for 1 of 1 resident (R38) observed receiving a pressure ulcer dressing change and the staff failed to wash their hands after perineal care for 1 of 4 residents (R29) observed receiving perineal care. Additionally, the facility failed to ensure a tubercle bacillus (TB) community risk assessment was completed according to their policy. This had the potential to affect all 43 residents in the facility Findings include: On 9/4/13, at 2:47 p.m. R38 was observed in bed. Licensed practical nurse (LPN)-A was observed to apply gloves. LPN-A was not observed to wash her hands prior to applying the gloves. LPN-A lifted R38's right leg and placed it on a pillow. R38s right foot was observed wrapped with kling. - At 2:48 p.m. LPN-A left the room and touched the door with her gloved hand, then immediately returned and took her medication cart key out of the lock in R38's night stand and then left the room again to get a scissor out of the medication cart in the hallway. LPN-A had not removed her gloves, washed her hands nor apply clean gloves. - At 2:49 p.m. LPN-A cut the kling off the right foot	21390		

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21390	Continued From page 50 with the scissor. There was a telfa pad on the right malleolus (ankle bone). There was a black spot on the second and fifth toe. There was also a scabbed area on the heel. LPN-A removed the telfa pad from the right malleolus and an open area was observed. - At 2:51 p.m. LPN-A went into the bathroom and obtained a wet wipe. LPN-A then wiped dried blood from between the 4th and 5th toe. LPN-A then removed her gloves and went into the bathroom and applied new gloves. No hand washing was observed. - At 2:53 p.m. LPN-A opened up a telfa dressing package and applied Santyl (debriding) ointment on the dressing. - At 2:54 p.m. LPN-A removed her gloves and left the room and went to the medication cart in the hallway. LPN-A then went to the supply closet across the hall and returned with a bottle of wound cleanser and gauze. When LPN-A re-entered the room she did not wash her hands and then applied gloves. - At 2:57 p.m. LPN-A cleansed the open area on the right malleolus with wound cleanser, and applied the telfa dressing. - At 2:58 p.m. LPN-A left the room with her gloves on, touched the door, and then brought her medication cart into the room. - At 2:59 p.m. LPN-A then removed her gloves and laid them on the top of the medication cart and checked the treatment order on the computer. - At 3:02 p.m. LPN-A went into the bathroom without washing her hands and applied gloves. - At 3:03 p.m. LPN-A wrapped the right foot with kling and applied tape. - At 3:05 p.m. LPN-A removed her gloves and placed them in the garbage can next to the bed. - At 3:06 p.m. LPN-A bagged up the garbage in the room	21390		

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21390	Continued From page 51 - At 3:08 p.m. LPN-A put the bagged garbage in the soiled utility room and did not wash her hands. - At 3:10 p.m. nursing assistant (NA)-G and LPN-A were going to check R38 for incontinence. - At 3:11 p.m. LPN-A went into the bathroom and applied gloves. - At 3:13 p.m. LPN-A bagged up the soiled brief that was in the garbage can and assisted to pull up R38s pants. - At 3:15 p.m. LPN-A removed her gloves and washed her hands in the bathroom. LPN-A shut the faucet handles off with both of her hands that she had just washed. - At 3:17 p.m. LPN-A put the garbage bag in the soiled utility room. On 9/4/13, at 3:18 p.m. LPN-A stated she was not organized at all for the dressing change. LPN-A stated she should have washed her hands or used hand sanitizer after removing the soiled dressing and applying the new dressing. LPN-A stated there was hand sanitizer in the room she could have used. LPN-A stated normally she would not have left the room that many times. LPN-A stated she had used a scissor from the medication cart for the dressing change, and was unsure if it was clean. LPN-A stated she did not clean the scissor with alcohol prior to using it. On 9/6/13, at 10:36 a.m. the director of nursing stated staff were to wash their hands or use hand sanitizer after removing gloves. The Hand Washing Policy revised 5/04, indicated staff were to decontaminate their hands before having direct contact with patients. Decontaminate hands after having contact with wound dressings. Decontaminate hands after removing gloves.	21390		

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21390	Continued From page 52 R29 did not receive personal cares with appropriate hand washing on the morning of 9/5/13. R29's diagnoses included anxiety, dementia with behavioral disturbances and paranoia. The quarterly Minimum Data Set (MDS) dated 7/9/13, indicated R29 had severe cognitive impairments and required extensive assistance with all activities of daily living, including extensive assistance with bed mobility and personal hygiene. R29's plan of care (POC) dated 7/17/13, indicated R29 was unable to care for himself with activities of daily living such as bathing, grooming, dressing and transferring. The POC directed the staff to provide assistance with 1 -2 staff members. On 9/5/13, at 9:00 a.m. nursing assistant (NA)-A and NA-C entered R29's room to assist with morning cares. - At 9:07 a.m. NA-C donned gloves and assisted R29 with washing his face, hands and upper body. NA-A assisted R29 with repositioning as needed to complete the cares. - At 9:11 a.m. NA-C rolled R29 onto his right side and assisted with perineal cares. R29 was observed to be incontinent of urine and had a small bowel movement. NA-C was not observed to remove the soiled gloves prior to applying a fresh incontinent brief. NA-C was observed with the same gloved hands to move the privacy curtain, open the bathroom door and place the soiled towels in a bag and then returned to R29 and assisted with dressing. She left her gloves on as she put on R29's shoes and positioned a	21390		

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21390	Continued From page 53 full body mechanical lift sheet under the resident. - At 9:20 a.m. NA-C moved R29's wheelchair and assisted NA-A with connecting the full body lift to the lift sheet. - At 9:22 a.m. NA-C assisted to guide R29 into the wheelchair with the same soiled gloves on. NA-C tucked the lift sling under R29 and walked into the bathroom, removed the gloves and washed her hands. On 9/5/13, at 9:40 a.m. NA-C confirmed she had left the soiled gloves on while she completed dressing R29 and moving items in the room. On 9/5/13, at 1:00 p.m. RN-A stated NA-C should have removed her gloves and washed hands prior to touching multiple areas in the room. The Hand Hygiene policy revised on 2/2010, directed staff to change gloves when moving from a contaminated body site to a clean body site on the same resident. The policy also directed the staff to "always" wash their hands after the removal of gloves. On 9/6/13, at 11:26 a.m. the director of hospital patient care revealed the TB (contagious infection involving the lungs) community risk assessment for the facility should be completed annually. On 9/26/13, at 12:25 p.m. the director of hospital patient care provided a copy of the facility's most current TB risk assessment worksheet dated 1/2011, which indicated the facility was classified as low risk. The director of hospital patient care confirmed this was the facility's most current TB risk assessment. The facility's Aerosol Transmissible Disease Standards/Tuberculosis Control Plan dated	21390		

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21390	Continued From page 54 12/2010, directed the facility at a minimum, to conduct a reassessment of TB risk annually. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. The director of nursing (DON) could establish a system to ensure the director of hospital patient care completed the TB risk assessment annually. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21405	MN Rule 4658.0810 Subp. 2 Resident Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines: Nursing Homes, Minnesota Rule 4658.0810 Subp 2 Resident Tuberculosis Program is waved. Condition of Waiver: - Follow the U.S. Centers for Disease Control and Prevention's "(Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," (MMWR) 2005; 54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements	21405		

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21405	Continued From page 55 ("CDC Guidelines"). Refer to the "CDC Guidelines" for complete definitions of terms. - Assign administrative responsibility for the tuberculosis (TB) infection control & prevention program to appropriate personnel. Administrative responsibilities include establishment of an infection control team (one or more individuals), completion (and periodic review) of a written TB risk assessment, and development (and periodic review) of a written TB infection control plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R1, R3, R5, R27, R41) reviewed received the required tuberculosis (TB) screening upon admission. Findings include: R1 was admitted to the facility on 1/22/2003. Review of the medical record indicated R1 received step one of the tuberculin skin test (TST) 1/22/2003. R3 was admitted to the facility on 11/30/2009. Review of the medical record indicated R3 received step one of the TST 11/30/2009. R5 was admitted to the facility on 3/2/2006. Review of the medical record indicated R5 received step one of the TST 3/2/2006. R27 was admitted to the facility on 11/10/2005. Review of the medical record indicated R27 received step one of the TST 11/10/2005.	21405		

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21405	Continued From page 56 R41 was admitted to the facility on 6/24/2009. Review of the medical record indicated R41 received step one of the TST 6/24/2009. R1, R3, R5, R27, and R41's medical records lacked a comprehensive symptomology screening for TB prior to the administration of step one of the TST. On 9/6/2013, at 10:27 a.m. registered nurse (RN)-C confirmed the facility lacks a specific comprehensive baseline TB screening assessment for residents upon admission. On 9/6/2013, at 11:35 a.m. the director of hospital patient care revealed she was unaware of a baseline TB screening assessment tool being used for newly admitted residents. The facility's Mantoux Test policy revision date 7/2009, directed staff to assess newly admitted residents for current symptoms of active TB disease. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure TB screening procedures were developed and implemented to ensure staff was free of TB prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21405		
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived.	21415		

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21415	Continued From page 57 Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.	21415		

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21415	Continued From page 58	21415		

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure 2 of 5 newly hired nursing assistants (NA-E, NA-F) were provided a two-step tuberculin skin test according to their guidelines.

Findings include:

Nursing assistant (NA)-E's hire date was 8/5/13. NA-E's tuberculin skin test documentation indicated NA-E had received step one of the TST on 8/5/13. This TST was read on 8/8/13, with a negative result. NA-E received the second step TST on 9/2/13, which was four days beyond the one to three weeks outlined in the facility's Baseline TB Screening Tool for Healthcare Workers document.

NA-F's hire date was 7/28/13. NA-F's tuberculin skin test documentation indicated
NA-F received step one of the TST on 7/29/13. This TST was read on 7/31/13, with a negative result. NA-F received the second step TST on 8/22/13, which was one day beyond the one to three weeks outlined in the facility's Baseline TB Screening Tool for Healthcare Workers document.

On 9/6/13, at 11:28 a.m. the director of hospital patient care confirmed if the second step TST was not done within the three week timeframe, the process should start over.

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21415	Continued From page 59 The facility's Tuberculosis Screening policy dated 1/2009, indicated initial and follow-up TST shall be administered, read, and interpreted according to current guidelines. The facility's Baseline TB Screening Tool for Healthcare Workers [undated] directed staff to perform the second step TST in one to three weeks, if the first step TST was negative. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could establish a system to ensure employees receive their TST according to the facility's policy. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21415		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain resident bathroom walls in a clean and sanitary condition free from black scuff marks for 7 of 28 resident bathrooms and 2 of 28 resident bedrooms free from gouged, scratched	21695		

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21695	Continued From page 60 walls. Findings include: During the environmental tour on 9/6/13, at 9:30 a.m. with the director of environmental services (DES) the following was observed: Room #101 had multiple areas of dark scuff marks on the bathroom walls. Room #105 had multiple areas of dark scuff marks on the bathroom walls. Room #106 had multiple areas of dark scuff marks on the bathroom walls. Room #107 had multiple areas of dark scuff marks on the bathroom walls. Room #108 had multiple areas of dark scuff marks on the bathroom walls and the wall next to the bed had gouged areas. At this time DES confirmed the gouge marks and stated it could have been from pushing the bed into the wall to clean. Room #128 had multiple areas of dark scuff marks on the bathroom walls Room #129 had multiple areas of dark scuff marks on the bathroom walls and the wall next to the bed had gouged areas. The EDS confirmed the gouge marks and stated it appeared some of the area had been repaired but had been gouged and scratched again before it was ever painted. The DES verified the findings on 9/16/13, at approximately 10:00 a.m. and stated housekeepers had access to magic erasers and they should be using them when they notice these black marks. He added some areas need to be repaired or filled in and then painted. The facility did not provide a policy related to to the maintenance of resident rooms or bathrooms.	21695		

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21695	Continued From page 61 SUGGESTED METHOD FOR CORRECTION: The director of environmental services could provide education to staff regarding housekeeping requirements. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide timely meals in a manner which promoted dignity for 3 of 3 residents (R13, R29, R15) in the sample who did not receive breakfast. Findings include: R13 did not receive breakfast in a timely dignified manner on the morning of 9/4/13. R13's diagnoses included muscle weakness and shortness of breath. The quarterly Minimum Data Set (MDS) dated 8/20/13, indicated R13 was alert and oriented, required extensive assistance with activities of daily living and supervision with	21805		

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FIRST CARE LIVING CENTER	900 HILLIGOSS BOULEVARD SOUTHEAST FOSSTON, MN 56542

(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
21805	Continued From page 62 eating. The plan of care (POC) dated 8/28/13, indicated R13 tolerated a regular diet and was independent with eating after the meal was set up by staff. On 9/4/13, at 9:00 a.m. R13 was observed in his room, seated in a wheelchair. Nursing assistant (NA)-C stated R13 was waiting for his bath. She stated she was not sure if R13 had received breakfast or not. NA-C reported she would look into assisting him with breakfast after providing cares to R13's roommate (R29). - At 9:25 a.m. NA-C completed cares on R29 and opened the curtain between the two residents. R13 stated "I thought you had forgotten about me." NA-C assured the resident and informed R13 she would assist with breakfast and asked what he wanted to eat. - At 9:30 a.m. R13 stated he was not sure if he wanted to eat breakfast. NA-C informed him it would be a long time before lunch and assured him she would bring him toast and coffee. NA-C then wheeled R13's roommate (R29) out of the room. - At 9:40 a.m. NA-C fed R29 breakfast in the dining room. She had not brought R13 toast or coffee as she had promised him. - At 9:45 a.m. R13 was wheeled out of his room towards the tub room. R13 explained to NA-D that he had not receive breakfast. NA-D continued to wheel R13 towards the tub room. - At 9:47 a.m. NA-C confirmed she had not delivered toast and coffee to R13 as promised. She was informed R13 was in the tub and stated R13 will remind her of the breakfast after his bath. - At 10:10 a.m. R13 was returned to his room from the tub room. - At 10:12 a.m. NA-D reported R13 had refused	21805		

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21805	Continued From page 63	21805		

breakfast and he would wait until lunch. She stated she did not know why R13 had not received breakfast.
- At 10:20 a.m. R13 stated he usually ate breakfast at the table when he was at home. He became tearful when he stated he did not know why he did not always get breakfast. When asked if he was hungry, R13 stated yes, but it was too late to eat it as it was only an hour until lunch was served. He confirmed the staff had offered to bring him breakfast but they had not returned with anything. R13 stated it was just too late and he was "mad."

On 9/4/13, at 11:30 a.m. R13 wheeled himself to the dining room and received lunch.
- At 12:06 p.m. R13 stated he was fully satisfied with his lunch, but stated, "I don't know why I didn't get breakfast today."

On 9/4/13, at 12:49 p.m. registered nurse (RN)-A stated she had been informed R13 had not received breakfast this morning. She stated R13 usually ate breakfast in the dining room and stated that was not R13's normal routine. She stated R13 had not been treated in dignified manner regarding his breakfast meal.

R29 did not receive breakfast on the morning of 9/6/13.

R29's diagnoses included dementia with behavioral disturbances, paranoid states and anxiety. The quarterly MDS dated 5/25/13, indicated R29 had severe cognitive impairment and required extensive assistance with all activities of daily living including eating.

R29's POC dated 7/17/13, directed staff to assist

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21805	Continued From page 64 with meals as needed. On 9/6/13, at 8:00 a.m. R29 was observed to be resting in bed with his eyes open. - At 9:00 a.m. R29 was observed sleeping in bed. - At 10:15 a.m. R29 continued to be sleeping in bed. - At 10:30 a.m. R29 remained in bed and had not received breakfast. - At 11:20 a.m. R29 was observed in the dining room during for lunch. R15 did not receive breakfast on the morning of 9/6/13. R15's diagnoses included depression and anxiety disorder. The significant change MDS dated 8/6/13, indicated R15 had severe cognitive impairment and required extensive assistance with activities of daily living. The MDS also indicated R15 was able to feed himself. R15's POC dated 5/22/13, indicated R15 could feed himself after the meal was set up by staff. The POC directed staff to set up his meal and open containers. On 9/5/13, at 8:00 a.m. R15 was served his breakfast meal in the dining room and was observed to eat 100% of the meal independently. On 9/6/13, at 8:00 a.m. R15 was awake and resting in bed. At 9:00 a.m. R15 stated he was hungry. At 10:15 a.m. R15 was observed to have dozed off in his bed. On 9/6/13, at 10:20 a.m. NA-A confirmed R15 and R29 had not received their breakfast. NA-A stated the facility was short two NA's therefore,	21805		

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21805	Continued From page 65 they were having difficulty keeping up with the needs of the residents. NA-A stated he would assist R15 and R29 with cares. On 9/6/13, at 10:20 a.m. dietary assistant (DA)-A stated she delivered the breakfast cart to the dining rooms at 7:30 a.m. and picked them up at 9:00 a.m. She stated she was not sure when the residents received their breakfast meals. She confirmed she had not been asked to leave a breakfast meal for R15 or R29. On 9/6/13, at 10:23 a.m. the certified dietary manager (CDM) stated the facility was currently serving the residents on a five meal plan. The residents were to be offered a continental breakfast between 7:30 a.m. to 9:00 a.m. lunch would be served at 11:00 a.m. snacks at 2:00 p.m. supper at 4:30 p.m. and a bedtime snack was to be served at 6:00 p.m. She stated with the five meal plan the residents were allowed to wake up on their own and they could eat when they were ready. She stated by 10:30 a.m. all of the residents' in the facility should have been offered some sort of breakfast. She explained, when the residents were admitted to the facility, she asked them what they like to eat and what was their normal routines which included what time they had eaten breakfast prior to admission. However, she confirmed she did not document the findings in the residents clinical records. The CDM explained if the residents chose to stay in bed after 9:30 a.m. the staff should be offering them something to eat either in the dining room or their rooms. The CDM was not aware R15 and R29 had not received breakfast meals. The CDM reviewed the bedtime snack documentation and reported R15 and R29 had received bedtime snacks on the evening of 9/5/13.	21805		

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21805	Continued From page 66 On 9/6/13, at 11:00 a.m. R15 and R29 were observed to be sitting in the dining room. R15 stated he had not received his breakfast meal. At 11:20 a.m. R15 and R29 were served lunch. The LTC (long term care) Resident Dietary Program and Dining Experience policy dated 3/6/07 , indicated the residents at the facility were to receive 3 meals and 2 snacks daily. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and the nutrition services manager could provide education for staff regarding the timing of the breakfast meal. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		