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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5J6W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**
2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH - HOMESTEAD**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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 **02/04/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(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 :
Jana Bromenshenkel, HFE NEII 02/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 02/17/2015 (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
02/01/1987
(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
11/24/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5428

On February 4, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 2, 2015. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to our PCR, completed on February 4, 2015, as of January 2, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 2, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 11, 2014 and December 30, 2014. The CMS Region V Office concurs and has authorized this Department to notify the facility of these actions:

Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 3, 2015, be rescinded. (42 CFR 488.417 (b))

In our letters of December 11, 2014 and December 30, 2014, we advised the facility 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), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 3, 2015, due to denial of payment for new admissions. Since the facility attained substantial compliance on January 2, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b for the results of this visit.

Effective January 2, 2015, the facility is certified for 32 skilled nursing faclity beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245428

February 17, 2015

Mr. Michael Hedrix, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, Minnesota 56636

Dear Mr. Hedrix:

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 January 2, 2015 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 11, 2015

Mr. Michael Hedrix, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On December 15, 2014, This Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred with our recommendation and authorized this Department to notify you of the following:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 3, 2015. (42 CFR 488.417 (b))

Also, in our letter of December 15, 2014, 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 October 3, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on October 3, 2014 and lack of verification of compliance of the health deficiencies at the time of our December 15, 2014 notice. The most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On December 11, 2014 a Post Certification Revisit (PCR) was completed to verify you facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the October 3, 2014 standard survey. Based on our visit we had determined your facility had not achieved substantial compliance. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

Since your facility had not achieved substantial compliance, this Department imposed the Category 1 remedy of State monitoring, effective January 4, 2015.

In additional, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letter of December 15, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of this action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 3, 2015, remain in effect. (42 CFR 488.417 (b))

On February 4, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 2, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 4, 2015, as of January 2, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 2, 2015.
In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of December 11, 2014 and December 30, 2014. 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 January 3, 2015, be rescinded. (42 CFR 488.417 (b))

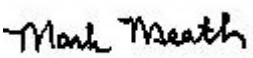
The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 3, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 3, 2015, is to be rescinded.

In our letters of December 11, 2014 and December 30, 2014, 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 January 3, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 2, 2015, 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 visit with the President of your facility's Governing Body.

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245428	A. Building B. Wing	2/4/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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 **F0205** Reg. # **483.12(b)(1)&(2)** LSC	Correction Completed **01/02/2015**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **01/02/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/02/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/02/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/02/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	02/11/2015	32601	02/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/3/2014			

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electronically Delivered
February 10, 2015

Mr. Michael Hedrix, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On February 10, 2015, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on February 3, 2015, imposed a daily fine in the amount of $1000.00.

On February 3, 2015, an acknowledgement was electronically received by the Department stating that the violation(s) had been corrected. A reinspection was held on February 4, 2015 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is $1,000.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $620.60, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $1,620.60 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Program Assurance Unit
Penalty Assessment Deposit Staff

OrigRevisistLicPATALtr

AH Form Approved

2/9/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00296	A. Building B. Wing	2/4/2015

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **01/02/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **01/02/2015**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **01/02/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	02/10/2015	32601	02/04/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/3/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5J6W

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**
2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH - HOMESTEAD**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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 **12/11/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (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
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE NEII 12/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/30/2015 (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
02/01/1987
(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
Posted 02/09/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/24/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5428

On December 15, 2014, the Department recommended the following remedy to the CMS Region V office, who concurred with our recommendation and authorized this Department to notify the facility of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015.

The facility is subject to a two year loss of NATCEP beginning October 3, 2014, as a result of the extended survey that identified substandard quality of care (SQC).

This was based on the deficiencies cited by this Department during the extended survey completed October 3, 2014 and lack of verification of compliance with the health deficiencies at the time of our December 15, 2014 notice.

On December 11, 2014, the Minnesota Department of Health completed a revisit to verify that the facility had achieved and maintained compliance with federal certification. Based on our visit, we
have determined that the facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 3, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiencies:

F0205 -- S/S: D -- 483.12(b)(1)&(2) -- Notice Of Bed-Hold Policy Before/upon Transfr
F0250 -- S/S: D -- 483.15(g)(1) -- Provision Of Medically Related Social Service.

The most serious deficiencies in the facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required. As result of our finding that your facility is not in substantial compliance, this Department imposed the category 1 remedy of State monitoring effective January 4, 2015. In addition, this Department recommended the following to the CMS Region V office

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015 remain in effect. (42 CFR 488.417 (b))

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 3, 2014.

Refer to the CMS 2567b, CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 15, 2014

Mr Michael Hedrix, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number F5428023

Dear Mr. Hedrix:

On October 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on October 3, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H), whereby corrections were required.

On November 18, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our extended survey, completed on October 3, 2014.

However, compliance with the health deficiencies issued pursuant to the October 3, 2014 extended survey has not yet been verified. The most serious health deficiencies in your facility at the time of the extended survey were found to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H), 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 January 3, 2015. (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 January 3, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 3, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Essentia Health - Homestead is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 3, 2014. 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.

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 April 3, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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 Health deficiencies (those preceded by a "F" tag), i.e., the plan of correction, request for waivers, should be directed to:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5428r1_70day

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 30, 2014

Mr. Michael Hedrix, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On December 15, 2014, the Department recommended the following remedy to the CMS Region V office, CMS concurred with our recommendation and authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015. (42 CFR 488.417 (b))

In addition, this Department notified you in our letter of December 15, 2014, 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 October 3, 2014.

This was based on the deficiencies cited by this Department during the extended survey completed October 3, 2014 and lack of verification of compliance with the health deficiencies at the time of our December 15, 2014 notice. The extended survey found the most serious deficiencies to be a pattern of deficiencies that constituted actual harm that was not immediate jeopardy (Level H), whereby corrections were required.

On December 11, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on October 3, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores

In addition, at the time of this revisit, we identified the following deficiencies:

F0205 -- S/S: D -- 483.12(b)(1)&(2) -- Notice Of Bed-Hold Policy Before/upon Transfr
F0250 -- S/S: D -- 483.15(g)(1) -- Provision Of Medically Related Social Service

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective January 4, 2015. (42 CFR 488.422)

In addition, this Department recommended the following action related to the imposed remedy in our letter of December 15, 2014:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 3, 2015 remain in effect. (42 CFR 488.417 (b))

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 3, 2014.

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.

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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 3, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 12/8 - 12/11/14. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected and new tags issued at the time of onsite PCR which are located on the CMS2567. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.	F 205		1/2/15

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

Electronically Signed | 01/13/2015

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F 205	Continued From page 1 At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the resident or legal representative written notification of the facility's bed hold policy at the time of any leave of absences (LOAs) for 1 of 1 resident (R31) reviewed who had an extended LOA. Findings include: R31's Physician Order Report dated 11/8/14 - 12/8/2014, identified R31's diagnoses as diabetes, foot cellulitis/abscess (skin infection), open wound on foot, diabetic retinopathy (a complication of diabetes which affects the eyes and causes vision problems), diabetic neuropathy (nerve disorder causing decrease in sensation), tobacco dependence and anemia. R31's admission Minimum Data Set (MDS) dated 8/23/14, indicated R31's cognition was intact; she was independent with transfers and required supervision for bed mobility, dressing, toileting and personal hygiene. R31 utilized a wheelchair for mobility around the unit. In addition, the MDS indicated R31 had an infected open skin lesion on her foot which required daily dressing changes. The Homestead Living and Rehabilitation Center Resident Sign Out Sheet indicated R31 had signed herself out on 35 occasions from 9/7/14 - 12/2/14. R31's Resident Progress Notes from 9/7/14 - 12/2/14, lacked any documentation regarding if	F 205	F 205 Element 1 Resident R31 has received a copy of the bed hold policy and is aware of the bed hold option. The LSW along with nursing have reviewed the bed hold policy with any LOA□s. Element 2 The bed hold policy was reviewed and remains current. The resident sign out book has been reviewed and all residents going out on an LOA have received a copy of the bed hold policy. A LOA/bed hold book has been revised to include: bed hold policy, sign out sheet and bed hold agreement to assure that all residents going out on LOA have a copy of the same and are aware of the policy. Element 3 The bed hold policy was reviewed and remains current. Education has been provided to nursing staff on the procedure for bed hold and the resident sign out book. Element 4 All resident LOAs will be audited weekly	

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F 205	Continued From page 2 the facility's bed hold policy had been reviewed with R31 on the 35 occasions R31 had signed herself out on an LOA. The social worker (SW)'s entries written in the Resident Progress Notes from 8/26/14 - 12/5/14, focused on R31's financial concerns; however lacked documentation regarding information provided to R31 regarding the facility's bed hold policy. On 12/8/14, at 3:02 p.m. the interim director of nursing (DON) confirmed the bed hold policy and not been initiated for any of R31's LOAs On 12/9/14, at 8:55 a.m. the SW verified R31 was on medical assistance and that R31 had used 24 of her 36 therapeutic leave days. On 12/10/14, at 4:29 p.m. the DON stated her expectations would be when someone signs themselves out for an LOA that the nurse should review the bed hold policy with the resident and this should be documented in the resident's medical record. On 12/10/14, at 4:47 p.m. the consulting RN confirmed R31 had been provided the bed hold policy upon admission, however had not received information on it since. The DEER RIVER HEALTHCARE CENTER Bed Hold policy dated 12/18/2006, indicated upon admission the facility would notify the resident of the bed hold option. Before a resident goes on a therapeutic leave, the facility would provide written notice to the resident and a family member or legal representative specifying the duration of the bed hold/therapeutic leave days.	F 205	by the LSW or designee for 4 weeks, monthly for 2 months and quarterly ongoing. Variances will be reported to the Administrator and reviewed at QAPI at least quarterly.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		1/2/15

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F 250	Continued From page 3 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically related social services related to discharge planning and coordination of leaves of absences (LOAs) for 1 of 1 resident (R31) reviewed who left the facility on numerous occasions on LOA without adequate preparation. In addition, the facility failed to follow up when R31 did not return from her LOA when expected. Findings include: R31's Physician Order Report dated 11/8/14 - 12/8/2014, identified R31's diagnoses as diabetes, foot cellulitis/abscess (skin infection), open wound on foot, diabetic retinopathy (a complication of diabetes which affects the eyes and causes vision problems), diabetic neuropathy (nerve disorder causing decrease in sensation), tobacco dependence and anemia. In addition, R31's current physician orders included metformin (oral diabetic medication) 1000 milligrams (mg) daily, hydrocodone-acetaminophen (pain medication) 5-325 mg as needed every six hours, Celexa (antidepressant) 10 mg daily, ferrous sulfate (iron medication) 324 mg daily, humulin 70/30 insulin injection 12 units (u) in the morning and 8 u before the evening meal, blood glucose checks to be done four times a day, and daily wound care with dressing change. R31's admission Minimum Data Set (MDS) dated 8/23/14, indicated R31's cognition was intact, she was independent with transfers and required	F 250	F 250 Element 1 Resident R31 has received a copy of the bed hold policy and is aware of the bed hold option. The LSW along with nursing have reviewed the bed hold policy with any LOA□s. Discharge planning has occurred with R31 with the resident planning to return to the community. Element 2 The bed hold policy was reviewed and remains current. The resident sign out book has been reviewed and all residents going out on an LOA have received a copy of the bed hold policy. A LOA/bed hold book has been revised to include: bed hold policy, sign out sheet and bed hold agreement to assure that all residents going out on LOA have a copy of the same and are aware of the policy. All resident care plans were reviewed to assure a discharge plan is in place. Discharge plans are reviewed at care conferences, upon request or as needed. Element 3 The bed hold policy and discharge policies were reviewed and updated as needed. Education has been provided to nursing staff on the procedure for bed hold, the resident sign out book, and	

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F 250	Continued From page 4 supervision for bed mobility, dressing, toileting and personal hygiene. R31 utilized a wheelchair for mobility around the unit. In addition, the MDS indicated R31 had an infected open skin lesion on her foot which required daily dressing changes. On 12/8/14, at 10:20 a.m. an entrance conference was held with the interim director of nursing (DON), consulting registered nurse (RN), and administrator. During this conference the DON stated on 12/2/14, R31 had signed out on a LOA with an expected return to the facility the next day (12/3/14). The DON stated R31 had not returned on 12/3/14, as planned, however; she thought R31 had returned briefly on 12/6/14, picked up her check and left again. At this time, R31 had not returned to the facility and the interim DON was unaware of where R31 currently could be located. The DON stated when someone doesn't return back from an LOA as expected, she would get the ombudsman, the social worker and provider involved. The DON stated they had just talked about R31's situation that morning at stand up and nothing further had been done at that time. On 12/8/14, at 10:34 a.m. the social worker (SW) stated she was aware R31 had not returned to the facility. The SW confirmed she had attempted to contact R31 on 12/5/14, via telephone; however was unable to speak with R31 and left her a message. The SW stated R31 had returned her call and had left a message on the SW's voice mail as the SW had already left for the day. The SW confirmed she currently was unaware of where R31 could be located or when she planned to return to the facility. On 12/8/14, at 10:53 a.m. registered nurse (RN)-A stated she had taken a phone call from R31 on 12/6/14, around 2 p.m. R31 was asking if she had any mail at the facility. RN-A stated R31	F 250	discharge planning. Element 4 All resident LOAs/discharges will be audited weekly by the LSW or designee for 4 weeks, monthly for 2 months and quarterly ongoing. Variances will be reported to the Administrator and reviewed at QAPI at least quarterly. F250 Addendum Element 1 Resident R31 was educated on risk vs. benefits of medication and treatments as ordered by the MD. She was also educated and demonstrated an understanding of medications/injections and usage. R31 is aware to give notice when going out to give time to prepare for her LOA in regards to meds and treatments. R31 was educated on the process of signing the book along with the bed hold agreement for each LOA she went on, along with the number of days she had been out of the facility. R31 was also educated on the process of notifying us if she was not going to return to the facility when originally planned and to provide a contact number where she could be reached. Element 3 All staff was educated on the process of what to do when someone does not return from an LOA as scheduled to include contacting the resident/responsible party, initiating a wellness check as appropriate and notifying the DON or LSW.	

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F 250	Continued From page 5	F 250		

said she was okay and that she had been in Duluth, but was back in Deer River now. R31 told RN-A that she would be back to the facility on Sunday (12/7/14). RN-A stated she talked to R31 briefly about her foot, and R31 stated she had someone change the dressing for her. However, the conversation RN-A had with R31 was not documented in the medical record on 12/6/14, nor was there an entry in the medical record on the day of R31's 12/2/14, LOA with regards to education regarding wound care or wound care supplies which may have been sent with R31 incase her dressing needed to be changed. RN-A stated she was aware that R31 had returned to the facility on Saturday, 12/6/14, picked up her check, and left again. RN-A was not working at the time R31 returned to the facility, and was unaware if R31 had been assessed prior to her leaving again and/or if supplies and medications had been sent with R31 when she left again (the medical record lacked documentation on 12/6/14, and 12/7/14).

On 12/8/14, at 11:00 a.m. licensed practical nurse (LPN)-A stated on Tuesday morning (12/2/14) she had sent with R31 a vial of insulin, a couple of insulin syringes and a day's worth of medication. LPN-A confirmed she had not sent any wound care or dressing changing supplies with R31.

On 12/8/14, at 11:06 a.m. RN-A confirmed when a resident doesn't return to the facility from a LOA, she would usually attempt to call the resident or family, if this was unsuccessful she would bring it to the team and social worker and document the incident. RN-A confirmed the staff had contact information for the social worker and DON if they needed to reach them at home or on the weekend or after hours. RN-A stated R31 had not returned from an LOA in the past, however, believed this was the longest R31 had been gone

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F 250	Continued From page 6 without returning to the facility. On 12/9/14, at 8:51 a.m. the SW confirmed the message she had received on her telephone from R31 on 12/5/14, stated R31 was okay, however, R31 did not state when she planned on returning to the facility. The SW stated they have allowed R31 to go out on an LOA with an open ended return/date. If they were worried about R31, they would try to call R31 or we would call the sheriff's department and have them do a wellness check. The SW stated if they were unable to locate R31, then they would report her missing and file an immediate report to the common entry point (CEP). The SW verified she had initiated a wellness check on 12/8/14, by the sheriff's department for R31. The SW confirmed R31 had been located at her home and had returned to the facility on 12/8/14, following the wellness check by the sheriff's department. On 12/9/14, at 9:05 a.m. the SW confirmed she had not documented the risks or benefits to R31 regarding her extended leaves and how those extended LOA's can affect her care. The Homestead Living and Rehabilitation Center Resident Sign Out Sheet indicated R31 had signed herself out on 35 occasions from 9/7/14 - 12/2/14. The Resident Progress Notes from 9/7/14 - 12/2/14, indicated R31 had signed herself out on a LOA 35 times. R31's Resident Progress Note entries indicated on: · 9/19/14, R31 had left on an LOA and hadn't called and hadn't returned back to the facility that evening. · 9/20/14, (recorded as a late entry on 9/21/14) indicated R31 had returned from LOA at 1:00 a.m. · 9/24/14, R31 had returned from LOA. R31	F 250		

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F 250	Continued From page 7 had stated she had not had supper. R31 was given something to eat and her insulin. The left foot dressing was changed; the dressing was dirty and smelled foul. · 10/6/14, R31 had returned from a LOA. It was noted that she had been incontinent of bowel and had not had her dressing changed since Friday morning (72 hours ago). The dressing on her left foot ulcer was documented to be dirty brown with drainage and hanging off of her foot. During the dressing change, there was a very foul odor and a reddened color over the lower tendon. · 10/19/14, R31 did not consistently receive her dressing changes due to her being out on LOA one to two times a week. · 10/25/14, at 2:19 p.m. R31 had signed herself out on an LOA yesterday and had not returned to the facility yet. No phone calls either. · 10/28/14, R31 remained on LOA and had missed her clinic appointment. · 10/29/14, R31 had returned to the facility last evening and dressing change done this morning. Dressing was saturated and continued to have a foul smell. · 11/4/14, that due to R31 being out on LOA and not returning when she states she would, seven doses of her recent antibiotic was left. · 11/15/14, R31 had received dressing/treatment upon her return from a three day LOA. The measurements were documented as 4 centimeters (cm) x 8 cm - irregular shaped with deepest depth measuring 1.8 cm, drainage was dark brown and foul smelling. R31 reported the treatment on her foot had not been done during this three day absence. · 12/4/14, R31 continues to be out on an LOA and this writer (SW) had not been able to follow up with R31 regarding her frustration that occurred on thanksgiving.	F 250		

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F 250	Continued From page 8 The SW's entries written in the Resident Progress Notes from 8/26/14 - 12/5/14, focused on R31's financial concerns. The entries lacked documentation regarding a discharge plan, information regarding the facility's bed hold policy, and or addressing R31's social services medical needs when R31 was on an LOA. The Care Conference Report dated 9/9/14, and 11/11/14, indicated R31 was at the facility on a short-term basis, however, lacked documentation of a specific discharge plan. On 12/10/14, at 4:22 p.m. the DON verified the documentation in R31's medical record lacked information regarding information pertaining to R31's LOAs and the care and treatment she received in preparation for her LOAs. On 12/10/14, at 4:26 p.m. the SW verified discharge planning should start upon admission and be reviewed at each care conference, and the interdisciplinary team was responsible for the development of the discharge plan. On 12/10/14, at 4:29 p.m. the DON stated her expectations would be when someone signs themselves out for an LOA that the nurse should provide the resident enough medication and treatment supplies to care for their medical needs when they were gone, be assured the resident understood the care that needed to be done while the resident was away, a contact number of where the resident could be reached, and an expected return date. In addition, the resident should sign out on the facility's sign out log and the bed hold policy should be reviewed with the resident. All of this information should be documented in the resident's medical record. On 12/10/14, at 4:31 p.m. the consulting RN verified the resident LOA expectations outlined by the interim DON had not been followed or documented in R31's medical record.	F 250		

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F 250	Continued From page 9 The Essentia Health Homestead DISCHARGE PLANNING policy dated 7/2013, indicated the SW functioned as the discharge planner for the facility. Upon admission the SW would meet with the resident and obtain a discharge plan. In addition, the SW would meet with the resident as needed to ensure the discharge plan was safe. The DEER RIVER HEALTHCARE CENTER Bed Hold policy dated 12/18/2006, indicated upon a therapeutic leave the resident would be provided a written notice which specified the duration of the bed hold/therapeutic leave days.	F 250		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation interview, and document review, the facility failed to ensure pressure ulcer monitoring had been completed according to the written care plan for 1 of 1 resident (R34) in the facility that had a pressure ulcer. Findings include: R34 was admitted to the facility, and the Resident Admission Record identified R34 had diagnoses that included, but were not limited to: Stage II pressure area, bilateral paralysis, major depressive disorder, atrial fibrillation, paranoia, neurogenic bladder.	{F 282}	F282 Element 1 Resident R34 wound has a comprehensive skin risk completed and care plan has been updated as appropriate. Weekly wound measures/protocol has been implemented. Element 2 A base line skin audit was performed on all residents to assure all residents with compromised skin were being addressed. All care plans were reviewed to assure they addressed potential skin risk. Care	1/2/15

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{F 282}	Continued From page 10 The care plan dated 11/10/14, identified the following: Resident has history of pressure ulcers and refusal to reposition/adhere to care schedule. The care plan interventions included the following: Resident admitted with Stage II pressure ulcers related to immobility and loose stools in the hospital. Stage 2 on buttocks/coccyx. Potential for further pressure ulcers related to ongoing immobility and bowel and bladder incontinence and non-compliance with repositioning and incontinence care. Interventions included: Assess the pressure ulcer for location, stage, size, weekly, have seen by NP wound specialist, and treat per recommendations. Conduct a systematic skin inspection weekly, on bath day. Report any skin concerns. Observe size of pressure ulcer daily with cares and dressing changes/monitoring, and report to physician or wound specialist and worsening in the pressure ulcer. The admission progress note dated 8/18/14, 5:09 p.m. identified the following related to R34's skin integrity: "Has excoriated area, stage 2, on coccyx that measures 3.5 X 3.2 cm surrounded by deep pink skin...Has 0.7 X 0.2 open slit at base of scrotum..." The physician progress note dated 8/26/14, identified that R34 had been evaluated for pressure ulcers and indicated "...forestage 2 on the right buttocks with a stage 1 surrounding...He does continue to have a small stage 2 ulcer on his right medial buttocks, as well as surrounding redness of both medial buttocks and the coccyx." Review of the resident's nursing home progress notes, and the physician documentation from 8/18/14-12/9/14, revealed that after the	{F 282}	plans were updated as appropriate. The care plans have been implemented and communicated to staff. Element 3 Nursing staff were educated on the Comprehensive care planning process along with following the care plan/team sheets as appropriate. Element 4 20% of resident skin care plan interventions will be monitored by the DON or designee for implementation weekly x 4 weeks, monthly for 1month, and quarterly ongoing. Variances will be reported to the Administrator and reviewed at QAPI at least quarterly.	

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{F 282}	Continued From page 11 aforementioned physician progress note dated 8/26/14, R34's pressure ulcers had not been assessed on a weekly basis. The following dates are when the physician progress notes or nursing progress notes documented any pressure ulcer assessment: - Physician progress note dated 10/23/14 (65 days later) - Physician progress note dated 10/27/14 - Physician progress note dated 10/30/14 - Nursing progress note dated 11/9/14 - Nursing progress note dated 11/20/14 (21 days later) - Nursing progress note dated 12/7/14 (18 days later) On 12/10/14, at 2:54 p.m. the skin integrity of R34 was observed and it was noted that there was an open area on R34's right side, below the anal area and off to the side of the testicle. This area was open, reddened, with serous drainage and appeared to be a stage 2 ulcer, oval in size and approximately 3 cm in length by 2 cm. The rest of the R34's bottom was reddened around the coccyx and sacral area - no other open areas visualized. Review of the Homestead Rehabilitation and Living Center policy Comprehensive Care Planning Process dated 11/12/14, had not addressed implementing the resident's comprehensive care plan. The consultant registered nurse was interviewed on 12/10/14, at 12:36 p.m. confirmed that R34's care plan for weekly assessment and measurement of pressure ulcers had not been followed according to the care plan.	{F 282}		

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{F 309}	Continued From page 12	{F 309}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure wounds had consistently been assessed, monitored and measured, according to facility policy for 1 of 1 resident (R31) who had a non-pressure related wound. Findings include: R31's Physician Order Report dated 11/8/14 - 12/8/2014, identified R31's diagnoses as diabetes, foot cellulitis/abscess (skin infection), open wound on foot, diabetic retinopathy (a complication of diabetes which affects the eyes and causes vision problems), diabetic neuropathy (nerve disorder causing decrease in sensation), tobacco dependence and anemia. R31's admission Minimum Data Set (MDS) dated 8/23/14, indicated R31's cognition was intact; she was independent with transfers and required supervision for bed mobility, dressing, toileting and personal hygiene. R31 utilized a wheelchair for mobility around the unit. In addition, the MDS indicated R31 had an infected open skin lesion on her foot which required daily dressing changes. R31's care plan dated 10/1/14, identified a problem area for skin as R31 had been admitted	{F 309}	F309 Element 1 Resident R31 wound has been assessed, monitored and measured by the wound team, MD and WCC,NP. Care plan was reviewed and updated as appropriate. Element 2 A base line skin audit was performed on all residents to assure all residents with compromised skin were being addressed according to current wound protocol. Element 3 The wound policy and procedure was reviewed and updated to include skin risk/braden assessments, skin inspection on bath day, weekly wound documentation, and NP/MD notification. Procedures were updated to reflect current standards of care. Education was provided to nursing staff. Element 4 DON or designee will monitor all residents	1/2/15

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{F 309}	Continued From page 13 for treatment to heal an open wound on her left foot due to a puncture injury. R31's care plan directed staff to keep the wound clean and dry as possible, minimize skin moisture and to provide treatment to the left foot daily as directed by the physician. R31's Physician Order Report dated 11/8/14 - 12/8/14, directed staff to change R31's dressing daily. The wound was to be cleansed with a wound cleanser; skin prep applied to the perimeter of the wound; a Seasorb AG (an absorbent dressing used for highly draining wounds) dressing applied with wet saline; then a lubricating jelly applied over the dressing, and covered with a gauze dressing. On 12/8/14, at 10:20 a.m. an entrance conference was held with the interim director of nursing (DON), consulting registered nurse (RN), and DON. During this conference the interim (DON) stated on 12/2/14, R31 had signed out on a LOA with an expected return to the facility the next day (12/3/14). The interim DON stated R31 had not returned on 12/3/14, as planned, however; she thought R31 had returned briefly on 12/6/14, picked up her check and left again. At this time, R31 had not returned to the facility and the interim DON was unaware of where R31 currently could be located. The interim DON stated when someone doesn't return back from an LOA as expected, she would get the ombudsman, the social worker and provider involved. The DON stated they had just talked about R31's situation this morning at stand up and nothing further had been done at this time. On 12/8/14, at 10:34 a.m. the social worker (SW) stated she was aware R31 had not returned to the facility. The SW confirmed she had attempted to contact R31 on 12/5/14, via telephone; however was unable to speak with R31 and left	{F 309}	with compromised skin weekly x 4 weeks, monthly for 2 months, and quarterly ongoing. Variances will be reported to the Administrator and reviewed at QAPI at least quarterly.	

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her a message. The SW stated R31 had returned her call and had left a message on the SW's voice mail as the SW had already left for the day. The SW confirmed she currently was unaware of where R31 could be located or when she planned to return to the facility.

On 12/8/14, at 10:53 a.m. registered nurse (RN)-A stated she had taken a phone call from R31 on 12/6/14, around 2pm. R31 was asking if she had any mail at the facility. RN-A stated R31 said she was okay and that she had been in Duluth, but was back in Deer River now. R31 told RN-A that she would be back to the facility on Sunday (12/7/14). RN-A stated she talked to R31 briefly about her foot, and R31 had stated she had someone change the dressing for her. However, the conversation RN-A had with R31 was not documented in the medical record on 12/6/14, nor was there an entry in the medical record on the day of R31's 12/2/14, LOA with regards to education regarding wound care or wound care supplies which may have been sent with R31 incase her dressing needed to be changed.

On 12/8/14, at 11:00 a.m. licensed practical nurse (LPN)-A stated on Tuesday morning (12/2/14), she had sent with R31 a vial of insulin, a couple of insulin syringes and a day's worth of medication. LPN-A confirmed she had not sent any dressing supplies with R31.

On 12/9/14, at 10:10 a.m. R31's foot wound was observed to be a large gaping irregular shaped wound on the bottom of R31's left foot, the wound was observed to run up the side of the foot and ended on the top of the foot. The wound bed was pink, there was no foul odor, however, there was a large amount of serous drainage noted. During interview with R31 at that time, she stated the wound had started as a cut from a glass on the

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bottom and side of the left foot and it had grown into a large gap. R31 confirmed that when she was out on leave of absence (LOA) she did not have the dressing consistently changed because supplies were not sent with for dressing changes. R31 stated she would often go to the clinic in the small town where she lived to have the dressing changed but the clinic was not open during holidays and weekends so she did not have it changed during those times.

On 12/8/14, at 3:45 p.m. the director of nursing (DON) confirmed the most current wound measurements of R31's wound on her left foot had been completed on 11/15/14, and the measurements were 4 centimeters (cm) x 8 cm x 1.8 cm in depth.

R31's 24 HOUR-INITIAL ADMISSION NURSING DOCUMENTATION form dated 8/19/14, indicated under the skin assessment section to "see note in matrix" (electronic documentation system). On review of R31's admission note in the electronic record dated 8/19/14, there lacked documentation of any skin assessment and or skin concerns.

R31's medical record revealed the following with regards to mention of wound measurement:

· R31's Hospital Outpatient Visit dated 8/27/14, indicated R31's had an ulceration on her left foot measuring 6.5 x 3 cm with a depth of 2 cm.

· R31's Resident Progress Notes (RPN) dated 9/22/14, indicated R31 had an open area on the bottom of her left foot measuring 5 cm x 8.5 cm and 1 cm in depth.

· R31's RPN dated 9/29/14, indicated wound measurement is 8.3 cm in length by 5 cm across and 1 cm deep. Yellow slough (dead tissue) noted in areas throughout the wound and tendons are exposed.

· R31's RPN dated 10/6/14, indicated R31 had

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returned from a leave of absence (LOA). It was noted that she had been incontinent of bowel and had not had her dressing changed since Friday morning (72 hours ago). The dressing on her left foot ulcer was documented to be dirty brown with drainage and hanging off of her foot. During the dressing change, there was a very foul odor and a reddened color over the lower tendon. The measurement was 1 cm in depth at the deepest point, 9 cm in length and 4.5 cm in width.

· R31's nursing home note from the physician dated 10/8/14, indicated R31's ulcer was "about 8 cm x 4 cm x 2 cm deep".

· R31's RPN dated 10/29/14, indicated dressing was saturated and continued to have a foul odor present. The distal end of the wound was gaped open a little more than prior (this entry lacked documentation of a wound measurement).

· R31's RPN dated 11/15/14, indicated R31 had received dressing/treatment upon her return from a three day LOA. The measurements were documented as 4 cm x 8 cm - irregular shaped with deepest depth measuring 1.8 cm, drainage was dark brown and foul smelling.

· R31's RPN, dated 12/9/14, indicated her foot wound measurements were 5.8 cm in length x 3.5 cm in width and 0.07 cm in depth (this indicated a 0.5 cm increase in the width of the wound from the measurement done 8/27/14, the closest date, to the date R31 was admitted to the facility).

R31's Treatment Administration History record from September to December 2014, revealed:

· 10 out of 30 days in September R31's foot treatment had been missed

· 15 out of 31 days in October R31's foot treatment had been missed

· 9 out of 30 days in November R31's foot treatment had been missed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 309}	Continued From page 17 · 7 out of 9 days for December R31's foot treatment had been missed The majority of the time the reason documented for these missed foot treatments was "resident unavailable". Additional comments documented on the Treatments Administration History record: · On 9/13/14 - "resident is LOA and do not know when she will return" · On 9/24/14 - "resident did not return from LOA" · On 10/4/14 - "resident did not return from LOA" · On 10/5/14 - "LOA since Friday 10/3/14" · On 11/11/14 - "resident did not return from LOA" R31's nursing notes (NN) dated 10/19/14, indicated R31 was scheduled for an appointment on 10/20/14, with a provider in the clinic to evaluate her left foot wound as there had been no progress toward wound healing. R31 had increased pain and the surrounding tissue of the wound had darkened significantly and the wound had an odorous drainage. In addition, the NN confirmed R31 had not consistently received her wound treatment as she had been out on LOA overnight approximately one to two times a week. R31's NN dated 11/15/14, at 1:06 p.m. indicated R31 had returned today after a three day LOA. R31 reported the treatment on her foot had not been done during this three day absence. The Homestead Living & Rehabilitation Center Resident Sign Out Sheet from September to December 2014, revealed R31 had signed herself out for an LOA on 35 occasions. R31's medical record in correlation to these LOA dates revealed a lack of documentation regarding what education R31 had been provided with regards to her wound care needs when she was out on an LOA or if wound care supplies had been sent with R31	{F 309}		

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{F 309}	Continued From page 18 in case a dressing change was needed. On 12/9/14, at 9:14 a.m. interim DON confirmed R31 had not had a comprehensive skin assessment beyond the 11/24/14, Braden (tool used to assess a resident's level of risk for developing a pressure ulcer) which R31 had been identified at not being at risk for development of a pressure ulcer. On 12/10/14, at 3:55 p.m. the DON confirmed it would be her expectation that the staff would follow the facility's wound care policy. The DON stated wounds should be assessed and measured weekly and this information should be documented in the medical record. On 12/10/14 at 4:04 p.m. DON and consulting nurse (CN) verified the most recent measurement of R31's left foot wound was completed on 12/9/14, and the measurements were 5.8 cm in length, 3.5 cm in width and 0.07 cm in depth. The DON and CN confirmed the current width of the wound on R31's left foot had increased from the first available measurement of 8/27/14, where the width of the wound had been documented as 3 cm (an increase of 0.5 cm). On 12/10/14, at 4:10 p.m. the DON confirmed the facility did not have a standardized wound care program in place to assure wounds were assessed, measured and monitored. In addition, the facility's wound care policy had not been followed. On 12/10/14, at 4:29 p.m. the interim DON stated her expectation would be whenever a resident was going out on a LOA they would be provided the medications and treatment supplies they would need when they were on the LOA; the resident understood the care which needed to be done while they were away; contact information of where the resident could be reached; and an expected date of return from the LOA. The	{F 309}		

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{F 309}	Continued From page 19 interim DON stated all of this information should be documented in the medical record. The interim DON and CN verified this had not been done for R31's numerous LOA's. R31's Braden Scale for Prediction of Pressure Sore Risk tool dated 11/24/14, indicated R31 was not at risk for developing a pressure sore, however the plan of care should continue to be followed. The Overview of wound care procedures policy [undated] directed staff to conduct a weekly skin inspection and document the results of this inspection. The Comprehensive Care Planning Process procedure dated 11/12/14, indicated one of the purposes of the care plan was to aid in preventing or reducing decline in a resident's status.	{F 309}		
{F 314} SS=D	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 pressure ulcer monitoring had been completed consistently according to the facility policy for 1 of 1 resident (R34) in the facility that had a pressure ulcer.	{F 314}	F314 Element Resident R34 had a comprehensive skin risk completed and care plan has been updated as appropriate. Weekly wound	1/2/15

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{F 314}	Continued From page 20 Findings include: R34 was admitted to the facility, and the Resident Admission Record identified R34 had diagnoses that included, but were not limited to: Stage II pressure area, bilateral paralysis, major depressive disorder, atrial fibrillation, paranoia, neurogenic bladder. The admission Minimum Data Set (MDS) dated 8/25/14, indicated R34 was unable to ambulate, required a wheelchair for all locomotion, required extensive assistance of 2 persons for transfers and bed mobility, and had one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer usually over a boney prominence) at the time of admission. The admission progress note dated 8/18/14, 5:09 p.m. identified the following related to R34's skin integrity: "Has excoriated area, stage 2, on coccyx that measures 3.5 X 3.2 cm surrounded by deep pink skin...Has 0.7 X 0.2 open slit at base of scrotum..." The physician progress note dated 8/26/14, identified that R34 had been evaluated for pressure ulcers and indicated "... stage 2 on the right buttocks with a stage 1 surrounding...He does continue to have a small stage 2 ulcer on his right medial buttocks, as well as surrounding redness of both medial buttocks and the coccyx." Review of the resident's nursing home progress notes, and the physician documentation from 8/18/14-12/9/14, revealed that after the aforementioned physician progress note dated 8/26/14, R34's pressure ulcers had not been	{F 314}	measures/protocol has been implemented. Element 2 A base line skin audit was performed on all residents to assure all residents with compromised skin were being addressed according to current wound protocol. Element 3 The wound policy and procedure was reviewed and updated to include skin risk/braden assessments, skin inspection on bath day, weekly wound documentation, and NP/MD notification. Procedures were updated to reflect current standards of care. Education was provided to nursing staff. Element 4 DON or designee will monitor all residents with compromised skin weekly x 4 weeks, monthly for 2 months, and quarterly ongoing. Variances will be reported to the Administrator and reviewed at QAPI at least quarterly.	

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{F 314}	Continued From page 21 assessed again until 10/23/14 (65 days later). -The physician progress note dated 10/23/14, indicated R34 had a long standing history of sacral pressure ulcers that waxed and waned in severity often due to his compliance with offloading (allowing for reperfusion of skin). The progress note identified the following related to R34's skin integrity: "Over his whole sacral area there is a stage I [intact skin with non-blanchable redness] ulcer. On the left upper thigh/gluteal fold area there is a quarter size stage 2 ulcer." The stage I and stage 2 ulcers had not been measured, nor was the pressure ulcer located right buttocks addressed as healed or not. -The physician progress note dated 10/27/14, identified the following related to R34's skin integrity: "He has got approximately 3 X 3 x 0.1 to 0.2 ulcerated area in the left ishium with some central dark areas. No surrounding erythema, induration or fluctuance." -The physician progress note dated 10/30/14, identified R34 had a stage 3 (full thickness tissue loss) ischial ulcer which measured 3.5 cm X 3.5 cm. -Nursing progress note dated 11/9/14, identified that R34 had an open area on crease between right buttock and posterior thigh that measured 2.2 cm X 2 cm X and 0.5 cm deep. There was no assessment of the stage 3 ischial ulcer previously identified on 10/30/14. The next documentation regarding assessment of R34's skin was completed on 11/20/14, (21 days later) when a nursing progress note identified that R34 had a stage 2 open area at the 12 o'clock position by the anus that measured 0.5 cm round	{F 314}		

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{F 314}	Continued From page 22	{F 314}		

open area and 0.25 cm deep. Another pressure ulcer was noted between the right buttock and thigh that measured 3 cm X 0.5 cm X 0.5 cm deep.

-Nursing progress note dated 12/7/14, (18 days later) identified that R34 had an open area in the crease of the right buttock and thigh that measured 2 cm X 1 cm X 0.75 cm deep. The nursing progress noted also identified R34 had a 1 cm diameter superficial open area with the top layer of skin missing proximal to the coccyx.

-A physician progress note dated 12/9/14, identified a pressure ulcer on the right posterior gluteal fold that measured 2.7 cm X 1.5 cm X 0.5 cm in depth. The documentation clearly showed a lack of consistent assessment and monitoring of multiple different pressure ulcers.

On 12/10/14, at 2:54 p.m. the skin integrity of R34 was observed and it was noted that there was an open area on R34's right side, below the anal area and off to the side of the testicle. This area was open, reddened, with serous drainage and appeared to be a stage 2 ulcer, oval in size and approximately 3 cm in length by 2 cm. The rest of the R34's bottom was reddened around the coccyx and sacral area - no other open areas visualized.

A tissue tolerance assessment (used to determine repositioning needs) was completed on 10/16/14, which identified that the resident had been admitted with pressure ulcers and maceration noted on the buttocks. The assessment indicated R34 had an open area near the scrotum 2.5 cm in length. Resident often refuses repositioning and changing of brief during

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{F 314}	Continued From page 23 day and night shift. When offloading was refused R34 is reproached at a later time. The assessment concluded R34 required repositioning ever 1-1.5 hours. The care plan dated 11/10/14, identified the following: Resident has chronic medical concerns related to an accident that involves paralysis of both legs bilaterally and loss of the right arm. The injury has also affected the spine and truck strength. Resident has a neurogenic bladder affecting continence of bowel and bladder. Resident has history of pressure ulcers and refusal to reposition/adhere to care schedule. The care plan interventions included the following: Monitor skin for breakdown daily, encourage repositioning per tissue tolerance. Resident admitted with Stage II pressure ulcers related to immobility and loose stools in the hospital. Stage 2 on buttocks/coccyx. Potential for further pressure ulcers related to ongoing immobility and bowel and bladder incontinence and non-compliance with repositioning and incontinence care Interventions included: Assess the pressure ulcer for location, stage, size, weekly, have seen by NP wound specialist, and treat per recommendations. Nutritional supplements per order. Conduct a systematic skin inspection weekly, on bath day. Report any skin concerns. Observe size of pressure ulcer daily with cares and dressing changes/monitoring, and report to physician or wound specialist and worsening in the pressure ulcer. Keep clean and dry, Maintain the head of the bed at the lowest degree of elevation possible. Turn and reposition every 1.5 to 2 hours in order to aide healing of skin breakdown and decrease risk of new skin breakdown. Resident will often refuse repositioning in this time frame.	{F 314}		

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{F 314}	Continued From page 24 Risks and benefits explained. Risks and benefits statement signed on file. Staff will encourage repositioning and reapproach as needed. Use lifting sheet to reposition resident in bed and position with soft pillows and pressure relief booties to feet. The HOMESTEAD LIVING AND REHAB CENTER policy for wound care procedures (undated) indicated that wound assessment and documentation would be completed weekly and a wound tracking log would be completed weekly as part of the quality assurance program. The consultant registered nurse was interviewed on 12/10/14, at 12:36 p.m. and stated that she could not identify how many pressure ulcer's R34 had, when they developed, or when they healed because the documentation for assessment and monitoring of R34's pressure ulcers were significantly lacking. The RN consultant confirmed that R34's wound assessment and documentation had not been completed according to the facility policy.	{F 314}		

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
245428	A. Building B. Wing	12/11/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/12/2014**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **11/12/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/12/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **11/12/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **11/15/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **11/12/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/12/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/12/2014**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **11/12/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	12/30/2014	18617	12/11/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/3/2014			

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on February 3, 2015

February 3, 2015

Mr. Michael Hedrix, Administrator
Essentia Health - Homestead
115 10th Avenue Northeast
Deer River, Minnesota 56636

Re: Project # S5428024

Dear Mr. Hedrix:

On December 11, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 3, 2014.

State licensing orders issued pursuant to the last survey completed on October 3, 2014 and found corrected at the time of this December 11, 2014 revisit, are listed on the attached Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on October 3, 2014, found not corrected at the time of this December 11, 2014 revisit and subject to penalty assessment are as follows:

20565 -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use - $300.00
20830 -- MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General - $350.00
20900 -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers - $350.00

The details of the violations noted at the time of this revisit completed on December 11, 2014 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of **$1,000.00** per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed , delivered or emailed to:

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00296	A. BUILDING: _____ B. WING _____	R 12/11/2014

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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: An onsite follow-up visit was completed on 12/11/14. During this onsite visit it was determined that the following corrections orders/s #0565, #0830, and #0900 were NOT corrected. This uncorrected order/s will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order/s will be reviewed for possible	{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 penalty assessment/s.	{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.	
{2 565}	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	{2 565}		1/2/15

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{2 565}	Continued From page 2 by: Uncorrected based on the following findings. The original licensing order issued on 10/03/14, will remain in effect. Penalty assessment issued. Based on observation interview, and document review, the facility failed to ensure pressure ulcer monitoring had been completed according to the written care plan for 1 of 1 resident (R34) in the facility that had a pressure ulcer. Findings include: R34 was admitted to the facility, and the Resident Admission Record identified R34 had diagnoses that included, but were not limited to: Stage II pressure area, bilateral paralysis, major depressive disorder, atrial fibrillation, paranoia, neurogenic bladder. The care plan dated 11/10/14, identified the following: Resident has history of pressure ulcers and refusal to reposition/adhere to care schedule. The care plan interventions included the following: Resident admitted with Stage II pressure ulcers related to immobility and loose stools in the hospital. Stage 2 on buttocks/coccyx. Potential for further pressure ulcers related to ongoing immobility and bowel and bladder incontinence and non-compliance with repositioning and incontinence care. Interventions included: Assess the pressure ulcer for location, stage, size, weekly, have seen by NP wound specialist, and treat per recommendations. Conduct a systematic skin inspection weekly, on bath day. Report any skin concerns. Observe size of pressure ulcer daily with cares and dressing changes/monitoring, and report to physician or wound specialist and worsening in the pressure ulcer.	{2 565}	Corrected	

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{2 565}	Continued From page 3 The admission progress note dated 8/18/14, 5:09 p.m. identified the following related to R34's skin integrity: "Has excoriated area, stage 2, on coccyx that measures 3.5 X 3.2 cm surrounded by deep pink skin...Has 0.7 X 0.2 open slit at base of scrotum..." The physician progress note dated 8/26/14, identified that R34 had been evaluated for pressure ulcers and indicated "...forestage 2 on the right buttocks with a stage 1 surrounding...He does continue to have a small stage 2 ulcer on his right medial buttocks, as well as surrounding redness of both medial buttocks and the coccyx." Review of the resident's nursing home progress notes, and the physician documentation from 8/18/14-12/9/14, revealed that after the aforementioned physician progress note dated 8/26/14, R34's pressure ulcers had not been assessed on a weekly basis. The following dates are when the physician progress notes or nursing progress notes documented any pressure ulcer assessment: - Physician progress note dated 10/23/14 (65 days later) - Physician progress note dated 10/27/14 - Physician progress note dated 10/30/14 - Nursing progress note dated 11/9/14 - Nursing progress note dated 11/20/14 (21 days later) - Nursing progress note dated 12/7/14 (18 days later) On 12/10/14, at 2:54 p.m. the skin integrity of R34 was observed and it was noted that there was an open area on R34's right side, below the anal area and off to the side of the testicle. This area was open, reddened, with serous drainage and	{2 565}		

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{2 565}	Continued From page 4 appeared to be a stage 2 ulcer, oval in size and approximately 3 cm in length by 2 cm. The rest of the R34's bottom was reddened around the coccyx and sacral area - no other open areas visualized. Review of the Homestead Rehabilitation and Living Center policy Comprehensive Care Planning Process dated 11/12/14, had not addressed implementing the resident's comprehensive care plan. The consultant registered nurse was interviewed on 12/10/14, at 12:36 p.m. confirmed that R34's care plan for weekly assessment and measurement of pressure ulcers had not been followed according to the care plan.	{2 565}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The	{2 830}	Corrected	1/2/15

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{2 830}	Continued From page 5 original licensing order issued on 10/03/14, will remain in effect. Penalty assessment issued. Based on observation, interview, and record review, the facility failed to ensure wounds had consistently been assessed, monitored and measured, according to facility policy for 1 of 1 resident (R31) who had a non-pressure related wound. Findings include: R31's Physician Order Report dated 11/8/14 - 12/8/2014, identified R31's diagnoses as diabetes, foot cellulitis/abscess (skin infection), open wound on foot, diabetic retinopathy (a complication of diabetes which affects the eyes and causes vision problems), diabetic neuropathy (nerve disorder causing decrease in sensation), tobacco dependence and anemia. R31's admission Minimum Data Set (MDS) dated 8/23/14, indicated R31's cognition was intact; she was independent with transfers and required supervision for bed mobility, dressing, toileting and personal hygiene. R31 utilized a wheelchair for mobility around the unit. In addition, the MDS indicated R31 had an infected open skin lesion on her foot which required daily dressing changes. R31's care plan dated 10/1/14, identified a problem area for skin as R31 had been admitted for treatment to heal an open wound on her left foot due to a puncture injury. R31's care plan directed staff to keep the wound clean and dry as possible, minimize skin moisture and to provide treatment to the left foot daily as directed by the physician. R31's Physician Order Report dated 11/8/14 - 12/8/14, directed staff to change R31's dressing daily. The wound was to be cleansed with a wound cleanser; skin prep applied to the perimeter of the wound; a Seasorb AG (an absorbent dressing used for highly draining	{2 830}		

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{2 830}	Continued From page 6	{2 830}		

wounds) dressing applied with wet saline; then a lubricating jelly applied over the dressing, and covered with a gauze dressing.
On 12/8/14, at 10:20 a.m. an entrance conference was held with the interim director of nursing (DON), consulting registered nurse (RN), and DON. During this conference the interim (DON) stated on 12/2/14, R31 had signed out on a LOA with an expected return to the facility the next day (12/3/14). The interim DON stated R31 had not returned on 12/3/14, as planned, however; she thought R31 had returned briefly on 12/6/14, picked up her check and left again. At this time, R31 had not returned to the facility and the interim DON was unaware of where R31 currently could be located. The interim DON stated when someone doesn't return back from an LOA as expected, she would get the ombudsman, the social worker and provider involved. The DON stated they had just talked about R31's situation this morning at stand up and nothing further had been done at this time.
On 12/8/14, at 10:34 a.m. the social worker (SW) stated she was aware R31 had not returned to the facility. The SW confirmed she had attempted to contact R31 on 12/5/14, via telephone; however was unable to speak with R31 and left her a message. The SW stated R31 had returned her call and had left a message on the SW's voice mail as the SW had already left for the day. The SW confirmed she currently was unaware of where R31 could be located or when she planned to return to the facility.
On 12/8/14, at 10:53 a.m. registered nurse (RN)-A stated she had taken a phone call from R31 on 12/6/14, around 2pm. R31 was asking if she had any mail at the facility. RN-A stated R31 said she was okay and that she had been in Duluth, but was back in Deer River now. R31 told RN-A that she would be back to the facility on

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{2 830}	Continued From page 7 Sunday (12/7/14). RN-A stated she talked to R31 briefly about her foot, and R31 had stated she had someone change the dressing for her. However, the conversation RN-A had with R31 was not documented in the medical record on 12/6/14, nor was there an entry in the medical record on the day of R31's 12/2/14, LOA with regards to education regarding wound care or wound care supplies which may have been sent with R31 incase her dressing needed to be changed. On 12/8/14, at 11:00 a.m. licensed practical nurse (LPN)-A stated on Tuesday morning (12/2/14), she had sent with R31 a vial of insulin, a couple of insulin syringes and a day's worth of medication. LPN-A confirmed she had not sent any dressing supplies with R31. On 12/9/14, at 10:10 a.m. R31's foot wound was observed to be a large gaping irregular shaped wound on the bottom of R31's left foot, the wound was observed to run up the side of the foot and ended on the top of the foot. The wound bed was pink, there was no foul odor, however, there was a large amount of serous drainage noted. During interview with R31 at that time, she stated the wound had started as a cut from a glass on the bottom and side of the left foot and it had grown into a large gap. R31 confirmed that when she was out on leave of absence (LOA) she did not have the dressing consistently changed because supplies were not sent with for dressing changes. R31 stated she would often go to the clinic in the small town where she lived to have the dressing changed but the clinic was not open during holidays and weekends so she did not have it changed during those times. On 12/8/14, at 3:45 p.m. the director of nursing (DON) confirmed the most current wound measurements of R31's wound on her left foot had been completed on 11/15/14, and the	{2 830}		

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{2 830}	Continued From page 8	{2 830}		

measurements were 4 centimeters (cm) x 8 cm x 1.8 cm in depth.
R31's 24 HOUR-INITIAL ADMISSION NURSING DOCUMENTATION form dated 8/19/14, indicated under the skin assessment section to "see note in matrix" (electronic documentation system). On review of R31's admission note in the electronic record dated 8/19/14, there lacked documentation of any skin assessment and or skin concerns.
R31's medical record revealed the following with regards to mention of wound measurement:
· R31's Hospital Outpatient Visit dated 8/27/14, indicated R31's had an ulceration on her left foot measuring 6.5 x 3 cm with a depth of 2 cm.
· R31's Resident Progress Notes (RPN) dated 9/22/14, indicated R31 had an open area on the bottom of her left foot measuring 5 cm x 8.5 cm and 1 cm in depth.
· R31's RPN dated 9/29/14, indicated wound measurement is 8.3 cm in length by 5 cm across and 1 cm deep. Yellow slough (dead tissue) noted in areas throughout the wound and tendons are exposed.
· R31's RPN dated 10/6/14, indicated R31 had returned from a leave of absence (LOA). It was noted that she had been incontinent of bowel and had not had her dressing changed since Friday morning (72 hours ago). The dressing on her left foot ulcer was documented to be dirty brown with drainage and hanging off of her foot. During the dressing change, there was a very foul odor and a reddened color over the lower tendon. The measurement was 1 cm in depth at the deepest point, 9 cm in length and 4.5 cm in width.
· R31's nursing home note from the physician dated 10/8/14, indicated R31's ulcer was "about 8 cm x 4 cm x 2 cm deep".
· R31's RPN dated 10/29/14, indicated dressing was saturated and continued to have a

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{2 830}	Continued From page 9	{2 830}		

foul odor present. The distal end of the wound was gaped open a little more than prior (this entry lacked documentation of a wound measurement).
· R31's RPN dated 11/15/14, indicated R31 had received dressing/treatment upon her return from a three day LOA. The measurements were documented as 4 cm x 8 cm - irregular shaped with deepest depth measuring 1.8 cm, drainage was dark brown and foul smelling.
· R31's RPN, dated 12/9/14, indicated her foot wound measurements were 5.8 cm in length x 3.5 cm in width and 0.07 cm in depth (this indicated a 0.5 cm increase in the width of the wound from the measurement done 8/27/14, the closest date, to the date R31 was admitted to the facility).
R31's Treatment Administration History record from September to December 2014, revealed:
· 10 out of 30 days in September R31's foot treatment had been missed
· 15 out of 31 days in October R31's foot treatment had been missed
· 9 out of 30 days in November R31's foot treatment had been missed
· 7 out of 9 days for December R31's foot treatment had been missed
The majority of the time the reason documented for these missed foot treatments was "resident unavailable". Additional comments documented on the Treatments Administration History record:
· On 9/13/14 - "resident is LOA and do not know when she will return"
· On 9/24/14 - "resident did not return from LOA"
· On 10/4/14 - "resident did not return from LOA"
· On 10/5/14 - "LOA since Friday 10/3/14"
· On 11/11/14 - "resident did not return from LOA"
R31's nursing notes (NN) dated 10/19/14,

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{2 830}	Continued From page 10 indicated R31 was scheduled for an appointment on 10/20/14, with a provider in the clinic to evaluate her left foot wound as there had been no progress toward wound healing. R31 had increased pain and the surrounding tissue of the wound had darkened significantly and the wound had an odorous drainage. In addition, the NN confirmed R31 had not consistently received her wound treatment as she had been out on LOA overnight approximately one to two times a week. R31's NN dated 11/15/14, at 1:06 p.m. indicated R31 had returned today after a three day LOA. R31 reported the treatment on her foot had not been done during this three day absence. The Homestead Living & Rehabilitation Center Resident Sign Out Sheet from September to December 2014, revealed R31 had signed herself out for an LOA on 35 occasions. R31's medical record in correlation to these LOA dates revealed a lack of documentation regarding what education R31 had been provided with regards to her wound care needs when she was out on an LOA or if wound care supplies had been sent with R31 in case a dressing change was needed. On 12/9/14, at 9:14 a.m. interim DON confirmed R31 had not had a comprehensive skin assessment beyond the 11/24/14, Braden (tool used to assess a resident's level of risk for developing a pressure ulcer) which R31 had been identified at not being at risk for development of a pressure ulcer. On 12/10/14, at 3:55 p.m. the DON confirmed it would be her expectation that the staff would follow the facility's wound care policy. The DON stated wounds should be assessed and measured weekly and this information should be documented in the medical record. On 12/10/14 at 4:04 p.m. DON and consulting nurse (CN) verified the most recent measurement of R31's left foot wound was completed on	{2 830}		

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{2 830}	Continued From page 11 12/9/14, and the measurements were 5.8 cm in length, 3.5 cm in width and 0.07 cm in depth. The DON and CN confirmed the current width of the wound on R31's left foot had increased from the first available measurement of 8/27/14, where the width of the wound had been documented as 3 cm (an increase of 0.5 cm). On 12/10/14, at 4:10 p.m. the DON confirmed the facility did not have a standardized wound care program in place to assure wounds were assessed, measured and monitored. In addition, the facility's wound care policy had not been followed. On 12/10/14, at 4:29 p.m. the interim DON stated her expectation would be whenever a resident was going out on a LOA they would be provided the medications and treatment supplies they would need when they were on the LOA; the resident understood the care which needed to be done while they were away; contact information of where the resident could be reached; and an expected date of return from the LOA. The interim DON stated all of this information should be documented in the medical record. The interim DON and CN verified this had not been done for R31's numerous LOA's. R31's Braden Scale for Prediction of Pressure Sore Risk tool dated 11/24/14, indicated R31 was not at risk for developing a pressure sore, however the plan of care should continue to be followed. The Overview of wound care procedures policy [undated] directed staff to conduct a weekly skin inspection and document the results of this inspection. The Comprehensive Care Planning Process procedure dated 11/12/14, indicated one of the purposes of the care plan was to aid in preventing or reducing decline in a resident's status.	{2 830}		

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{2 900}	Continued From page 12	{2 900}		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 10/03/14, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to ensure pressure ulcer monitoring had been completed consistently according to the facility policy for 1 of 1 resident (R34) in the facility that had a pressure ulcer. Findings include: R34 was admitted to the facility, and the Resident Admission Record identified R34 had diagnoses that included, but were not limited to: Stage II pressure area, bilateral paralysis, major	{2 900}	Corrected	1/2/15

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{2 900}	Continued From page 13 depressive disorder, atrial fibrillation, paranoia, neurogenic bladder. The admission Minimum Data Set (MDS) dated 8/25/14, indicated R34 was unable to ambulate, required a wheelchair for all locomotion, required extensive assistance of 2 persons for transfers and bed mobility, and had one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer usually over a boney prominence) at the time of admission. The admission progress note dated 8/18/14, 5:09 p.m. identified the following related to R34's skin integrity: "Has excoriated area, stage 2, on coccyx that measures 3.5 X 3.2 cm surrounded by deep pink skin...Has 0.7 X 0.2 open slit at base of scrotum..." The physician progress note dated 8/26/14, identified that R34 had been evaluated for pressure ulcers and indicated "... stage 2 on the right buttocks with a stage 1 surrounding...He does continue to have a small stage 2 ulcer on his right medial buttocks, as well as surrounding redness of both medial buttocks and the coccyx." Review of the resident's nursing home progress notes, and the physician documentation from 8/18/14-12/9/14, revealed that after the aforementioned physician progress note dated 8/26/14, R34's pressure ulcers had not been assessed again until 10/23/14 (65 days later). -The physician progress note dated 10/23/14, indicated R34 had a long standing history of sacral pressure ulcers that waxed and waned in severity often due to his compliance with offloading (allowing for reperfusion of skin). The progress note identified the following related to R34's skin integrity: "Over his whole sacral area	{2 900}		

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{2 900}	Continued From page 14	{2 900}		

there is a stage I [intact skin with non-blanchable redness] ulcer. On the left upper thigh/gluteal fold area there is a quarter size stage 2 ulcer." The stage I and stage 2 ulcers had not been measured, nor was the pressure ulcer located right buttocks addressed as healed or not.

-The physician progress note dated 10/27/14, identified the following related to R34's skin integrity: "He has got approximately 3 X 3 x 0.1 to 0.2 ulcerated area in the left ishium with some central dark areas. No surrounding erythema, induration or fluctuance."

-The physician progress note dated 10/30/14, identified R34 had a stage 3 (full thickness tissue loss) ischial ulcer which measured 3.5 cm X 3.5 cm.

-Nursing progress note dated 11/9/14, identified that R34 had an open area on crease between right buttock and posterior thigh that measured 2.2 cm X 2 cm X and 0.5 cm deep. There was no assessment of the stage 3 ischial ulcer previously identified on 10/30/14.

The next documentation regarding assessment of R34's skin was completed on 11/20/14, (21 days later) when a nursing progress note identified that R34 had a stage 2 open area at the 12 o'clock position by the anus that measured 0.5 cm round open area and 0.25 cm deep. Another pressure ulcer was noted between the right buttock and thigh that measured 3 cm X 0.5 cm X 0.5 cm deep.

-Nursing progress note dated 12/7/14, (18 days later) identified that R34 had an open area in the crease of the right buttock and thigh that measured 2 cm X 1 cm X 0.75 cm deep. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00296	A. BUILDING: _____ B. WING _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 900}	Continued From page 15 nursing progress noted also identified R34 had a 1 cm diameter superficial open area with the top layer of skin missing proximal to the coccyx. -A physician progress note dated 12/9/14, identified a pressure ulcer on the right posterior gluteal fold that measured 2.7 cm X 1.5 cm X 0.5 cm in depth. The documentation clearly showed a lack of consistent assessment and monitoring of multiple different pressure ulcers. On 12/10/14, at 2:54 p.m. the skin integrity of R34 was observed and it was noted that there was an open area on R34's right side, below the anal area and off to the side of the testicle. This area was open, reddened, with serous drainage and appeared to be a stage 2 ulcer, oval in size and approximately 3 cm in length by 2 cm. The rest of the R34's bottom was reddened around the coccyx and sacral area - no other open areas visualized. A tissue tolerance assessment (used to determine repositioning needs) was completed on 10/16/14, which identified that the resident had been admitted with pressure ulcers and maceration noted on the buttocks. The assessment indicated R34 had an open area near the scrotum 2.5 cm in length. Resident often refuses repositioning and changing of brief during day and night shift. When offloading was refused R34 is reproached at a later time. The assessment concluded R34 required repositioning ever 1-1.5 hours. The care plan dated 11/10/14, identified the following: Resident has chronic medical concerns related to an accident that involves paralysis of both legs bilaterally and loss of the right arm. The injury has also affected the spine and truck	{2 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00296	A. BUILDING: _____ B. WING _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 900}	Continued From page 16	{2 900}		

strength. Resident has a neurogenic bladder affecting continence of bowel and bladder. Resident has history of pressure ulcers and refusal to reposition/adhere to care schedule. The care plan interventions included the following: Monitor skin for breakdown daily, encourage repositioning per tissue tolerance. Resident admitted with Stage II pressure ulcers related to immobility and loose stools in the hospital. Stage 2 on buttocks/coccyx. Potential for further pressure ulcers related to ongoing immobility and bowel and bladder incontinence and non-compliance with repositioning and incontinence care Interventions included: Assess the pressure ulcer for location, stage, size, weekly, have seen by NP wound specialist, and treat per recommendations. Nutritional supplements per order. Conduct a systematic skin inspection weekly, on bath day. Report any skin concerns. Observe size of pressure ulcer daily with cares and dressing changes/monitoring, and report to physician or wound specialist and worsening in the pressure ulcer. Keep clean and dry, Maintain the head of the bed at the lowest degree of elevation possible. Turn and reposition every 1.5 to 2 hours in order to aide healing of skin breakdown and decrease risk of new skin breakdown. Resident will often refuse repositioning in this time frame. Risks and benefits explained. Risks and benefits statement signed on file. Staff will encourage repositioning and reapproach as needed. Use lifting sheet to reposition resident in bed and position with soft pillows and pressure relief booties to feet.

The HOMESTEAD LIVING AND REHAB CENTER policy for wound care procedures (undated) indicated that wound assessment and documentation would be completed weekly and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00296	A. BUILDING: _____ B. WING _____	R 12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 900}	Continued From page 17 wound tracking log would be completed weekly as part of the quality assurance program. The consultant registered nurse was interviewed on 12/10/14, at 12:36 p.m. and stated that she could not identify how many pressure ulcer's R34 had, when they developed, or when they healed because the documentation for assessment and monitoring of R34's pressure ulcers were significantly lacking. The RN consultant confirmed that R34's wound assessment and documentation had not been completed according to the facility policy.	{2 900}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00296	A. Building B. Wing	12/11/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **11/12/2014**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **11/12/2014**	ID Prefix **20930** Reg. # **MN Rule 4658.0525 Subp. 1** LSC	Correction Completed **11/12/2014**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4** LSC	Correction Completed **11/12/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **11/12/2014**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 1** LSC	Correction Completed **11/12/2014**
ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **11/12/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** LB/mm	**Date:** 12/30/2014	**Signature of Surveyor:** 18617	**Date:** 12/11/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/3/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245428	A. Building B. Wing 01 - NURSING HOME	11/18/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH - HOMESTEAD	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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 Reg. # NFPA 101 LSC K0052	Correction Completed 11/18/2014	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 11/18/2014	ID Prefix Reg. # NFPA 101 LSC K0069	Correction Completed 11/18/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/mm	Date: 12/15/2014	Signature of Surveyor: 03005	Date: 11/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/30/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 5J6W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**

2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH - HOMESTEAD**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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 **10/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (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
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NEII 11/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 11/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(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
Posted 11/24/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5428

On October 3, 2014 an extended survey was completed at this facillity. The survey found deficiencies with the most serious to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy. In addition, conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. The facility has been given an opportunity to correct before remedies would be imposed. The facility is prohibited from conduct NATCEP training for two years, effective October 3, 2014. Post Certification Revisit to follow.

Refer to the CMS 2567 for both health and life safety code along with the faciliyt's plan of correction.

Please note, the facility's ame has changed to Essentia Health - Homestead. Preveiously the facility's name was Homestead Rehabilitation and Liviing Center. Refer to the MN1513 confirming the facilty name change and notice from this office dated November 20, 2014 confirming the change has been completed.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

October 22, 2014

Mr. Michael Hedrix, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428024

Dear Mr. Hedrix:

On October 3, 2014, an extended 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 a pattern of deficiencies that constitute actual harm that is not immediate jeopardy (Level H), 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>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>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (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 November 12, 2014, 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 November 12, 2014 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Homestead Rehabilitation & Living Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective October 3, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct oan extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter.

Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 January 3, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 3, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 10/2/14-10/3/14.	F 000		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		11/12/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/31/2014

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 279	Continued From page 1 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 care plan to address medications and appropriate interventions to meet the needs for 1 of 5 residents (R31) whose medication regimen was reviewed; failed to develop a care plan related to pain interventions for 3 of 3 residents (R6, R25, R11) who had expressed pain; and failed to develop a care plan for hair care for 1 of 4 residents (R9) who routinely refused assistance with hair care. Findings include: R31's care plan dated 10/1/14, did not address the use of Celexa (an antidepressant) 10 milligrams (mg) daily for depressed mood and adjustment disorder, and did not address the use of Ferrous Sulfate (an iron supplement) 324 mg twice daily to treat a lack of red blood cells. R31's physician's orders dated 9/10/14, directed Ferrous Sulfate 324 mg two times a day. R31's physician's orders dated 9/16/14, directed Celexa 10 mg daily. At 8:44 a.m. registered nurse (RN)-A verified the Ferrous Sulfate and Celexa should be addressed on the care plan. R6 experienced continued left leg pain and the care plan did not address interventions to minimize/reduce pain.	F 279	Element 1 Residents (R6, R25, and R11) have had a comprehensive assessment of pain. The assessment tool has been analyzed and updated and comprehensive care plans have been developed and implemented. Resident (R9) has been interviewed and a care plan is in place to encourage the highest level of hair care acceptable to the resident. Resident (R31) has an updated care plan to address the medication regimen. The same resident (R31) has been evaluated for wheel chair positioning and the care plan has been updated. Element 2 All resident care plans have been reviewed and updated to reflect appropriate pain management, hair care choices, medication regimens, and wheel chair positioning. Element 3 The facility□s care planning policy has been updated as necessary and education has been provided to licensed nursing staff. Element 4 20% of resident care plans will be audited weekly by the DON or designee for 4 weeks, then monthly for 2 months, and	

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F 279	Continued From page 2 R6's care plan dated 6/4/14, identified an alteration in comfort related to carpal tunnel syndrome and muscle spasticity secondary to cerebral palsy. The care plan directed the staff to anticipate her needs and respond in a timely manner. The care plan did not direct the staff how to minimize potential pain nor did it include non-pharmacological interventions to minimize R6's pain. On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh." No staff members were observed in the dining room as R6 cried holding her head. A few moments later nursing assistant (NA)-A walked up to R6 and escorted her to her room. On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head. On 10/2/14, at 9:10 a.m. NA-A stated R6 cried out in pain every day. NA-A stated R6 will complain while sitting in her wheelchair. NA-A reported R6 receives pain medications for pain management but she often has to wait until it is time for the next medication. NA-A stated R6 frequently watches the clock in her room waiting for the next pain medication. On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes	F 279	thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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F 279	Continued From page 3 care of the pain for about an hour. R6 explained the pain in her left leg wakes her at night and she often has to watch the clock to wait for her next dose of pain medications. R6 described the pain as a "toothache that never goes away." She stated the pain prevented her from participating in many of the activities in the facility because sometimes it was better in the chair... and other times it was better in bed. R6 described the pain as being at an 8 or 9 on a 0-10 (10 worst) pain scale daily. R6 stated she has to watch the clock to make sure she is receiving her pain medications. On 10/2/14, at 10:00 a.m. NA-D stated R6 expressed pain in her left leg every day. She stated she attempts to reposition R6 in bed or rub her leg, but it usually does not give R6 pain extended relief. She stated R6 may have a few moments of pain relief, but it did not last long. On 10/2/14, at 10:10 a.m. licensed practical nurse (LPN)-B stated R6 reported complaints of pain "all of the time." She stated R6 will request pain medications and will watch the clock waiting for the four hours to pass before she can ask for the next pill. LPN-B stated R6 was uncomfortable, "I wish we could find something to giver her relief." On 10/2/14, at 11:20 a.m. the consultant RN confirmed R6 experienced daily pain daily and the care plan did not address pharmacological and non-pharmacological interventions to reduce/minimize R6's pain. R25's care plan dated 8/5/14, did not address the need to elevate legs due to edema, the use of	F 279		

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Demedex (a diuretic) 10 mg daily for weight gain/edema, or the use of as needed acetaminophen (Tylenol) 650 mg for break through pain. Nor did it address the use of non-pharmacological interventions to relieve pain other than ambulation.

R25's care plan last revised 8/5/14, indicated pain would be rated on a scale of 1-10 by resident and as needed (PRN) medications may be given. Interventions indicated R25 was to participate in ambulation and exercises to decrease pain. There were no other non-pharmacological interventions included on the care plan.

The 10/2/2014, physician's order report indicated R25's current medications included: methotrexate sodium (used to treat severe rheumatoid arthritis) 25/ml (milliliters) injection every 7 days, Fentanyl patch every 72 hours 50 mcg/hr (hour), change every 3 days, Demadex 10 mg every day, Percocet 5/325 mg 1 tablet every 4 hours PRN, acetaminophen 325 mg two tablets PRN every 4 hours for minor or breakthrough pain and give between scheduled Percocet doses if needed. Do not exceed 3000 mg [acetaminophen] total in 24 hours.

During interview on 9/30/2014, at 7:42 p.m. R25 stated she had discomfort in both of her legs. Review of the EMAR indicated on 10/1/14, at 1:57 a.m. PRN Percocet 5/325 mg. one tablet was given due to left leg, and right and left heel pain.

During interview on 10/1/2014, at 7:05 a.m. R25 stated as she lay in bed moaning "oh my leg hurts." Surveyor asked her if she had told anybody and she stated, "No, they know and all staff are busy." At 7:15 a.m. R25 stated both of

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her legs hurt, "they are hard as a rock, just feel them." At that time R25 removed her covers and showed the surveyor her legs that appeared shiny and firm to the touch.

At 7:45 a.m. nursing assistant (NA)-D was observed assisting R25 wash up for the day. R25 stated her groin/crotch area was swelled up and so tight. At 7:50 a.m. R25 stated as she transferred from toilet to w/c, "oh my knees hurt." NA-D stated, "Oh that darn arthritis."

At 8:15 a.m. R25 stated her legs hurt and added, "They don't stop hurting." NA-D wheeled her to the dining room.

On 10/1/14, at 8:27 a.m. LPN-A gave R25 PRN Percocet 5/325 mg. for pain. R25 rated her pain at an 8.

On 10/1/14, at 10:00 a.m. RN-B verified the care plan did not address the items and should be on the care plan

R11 experienced continued right knee pain and the care plan did not address interventions to minimize/reduce pain other than to administer medications.

R11's care plan dated 7/17/14, identified R11 had alteration in comfort related to pain secondary to history of compression fractures of her back and indicated R11 would verbally state pain was 2-3 on a verbal scale of 0-10 after administration of pain medication. The care plan directed staff to administer medications as ordered for pain and to monitor for effectiveness of pain medications and

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F 279	Continued From page 6 possible side effects. The care plan did not identify or address R11's right knee/joint pain, nor did it identify non-pharmacological interventions for pain. On 10/2/14, at 9:04 a.m. R11 was observed in her room, seated in a recliner. R11 stated she had been having a lot of problems with her right knee and raised her pant leg above her knee and began to rub it. The knee was observed to be swollen. R11 stated she was given pain pills for the knee pain and stated they lasted a little while "but they don't last forever." She stated that on 10/1/14, she was given cold packs and that helped for a little bit. R11 stated the pain kept her up at night at times and the previous night she was "up a lot" until she finally got a pain pill. R11 stated the pain medication lasted for about 4 hours before her knee began hurting again. R11 also stated she asked for a pain pill a couple of times a day and identified her pain right now at an 8 out of 10 on a 1 to 10 scale. On 10/02/2014, at 10:02 a.m. R11 was observed ambulating back toward her room after her bath. R11 was observed to be limping on her right leg. R11 stated her knee felt much better after her whirlpool bath. On 10/02/2014, at 10:48 a.m. NA-B stated R11 had pain daily and may have had more pain lately since recently bumping her right knee. On 10/02/2014, at 10:55 a.m. NA-D stated R11 had pain every day and received pain medication for the pain. NA-D indicated she was not aware of any non-pharmacological interventions for the relief of R11's pain nor was she aware of factors that aggravated R11's pain. NA-D further	F 279		

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indicated R11's pain was mostly in her knees.

On 10/02/2014, at 2:39 p.m. LPN-B stated R11 received scheduled pain medication three times a day and could also have PRN pain medication for her knee pain. LPN-B indicated R11 had used warm packs on her legs previously, but stated they had only done so very occasionally, and it had been about a month since the warm packs had been used. LPN-B indicated that the warm packs had been effective, and R11 had liked the warm packs when used in the past. LPN-B indicated that if R11 currently indicated she was in pain and had just had a pain pill, they instructed her to elevate her legs and take it easy until the medication worked.

On 10/02/2014, at 3:12 p.m. interim DON and consultant RN confirmed the care plan did not identify interventions to minimize R11's right knee pain.

R9's care plan did not address her routine refusal of assistance with hair care.

R9's Resident Admission Record dated 10/2/14, indicated R9 had diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, major depressive disorder, hemiplegia (paralysis on one vertical half of the body), and polyneuropathy in diabetes (nerve damage causing numbness, loss of sensation and sometimes pain in feet, legs and hands caused by diabetes)

R9's quarterly Minimum Data Set (MDS) dated 8/30/14, indicated R9 had severe cognitive impairment and required extensive assistance of

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F 279	Continued From page 8 two staff for personal hygiene. R9's activities of daily living (ADL)/Functional Care Area Assessment (CAA) dated 12/2/13, indicated R9 had hemiplegia and overall weakness and spent her days in bed per her preference. The CAA indicated R9 would occasionally get up for bingo. The CAA also identified R9 required maximum to total assist with dressing, grooming and bathing and R9 refused to get out of bed except occasionally for bingo or a bath. R9's care plan dated 9/2/14, identified R9 had a self care deficit related to grooming and bathing related to history of stroke with left sided weakness and paralysis. The care plan also indicated R9 stayed in bed and wore house dresses daily. The care plan directed staff R9 required assist of one with grooming, and comb hair daily. The care plan further directed staff R9 required assist of one with partial bathing twice per day with hair wash in bed weekly, or if resident would get up hair wash in beauty shop. The care plan did not identify R9's routine refusal of hair care or identify interventions to minimize/reduce refusal of care. On 09/29/2014, at 3:53 p.m. R9 was observed to be lying in bed. Her hair was observed to be unclean. On 9/30/14, at 1:18 p.m. R9 observed resting in bed. Her hair was noted to be unclean. On 10/01/2014, at 7:49 a.m. R9 was observed lying in bed. Her hair was observed to be unclean.	F 279		

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F 279	Continued From page 9 On 10/1/14, at 7:55 a.m. R9 stated she receives a bed bath. She stated she received a bed bath on 9/30/14, but did not know if her hair had been washed. On 10/01/2014, at 9:42 a.m. NA-B and NA-D stated R9 usually refused to have her hair washed. NA-B indicated R9 does not like the mess it caused to wash her hair in bed. NA-D indicated R9 had refused alternatives such as cap shampoo or dry shampoo. NA-B stated R9 would sometimes allow her hair to be washed in the beauty shop when she got up. NA-B and NA-D stated R9 would frequently go longer than 2 weeks without washing her hair. Both indicated R9 liked to have her hair colored and would allow her hair to be washed at that time. On 10/01/2014, at 11:55 a.m. NA-B indicated she reapproached R9 and she refused a hair wash. On 10/01/2014, at 1:47 p.m. RN-A stated R9 was supposed to have her hair washed weekly. RN-A confirmed R9's hair was "grimy" on 9/30/14. RN-A stated R9 was able to express her own preferences and needs, and would often refuse such care. On 10/02/2014 at 8:43 a.m. the interim DON confirmed the refusal of hair care and grooming was not on R9's care plan, and verified it should have been. On 10/02/2014, at 8:48 a.m. R9 stated she didn't like to have her hair washed in bed, she didn't like the mess it created. R9 stated she liked to have her hair washed at the beauty shop,and would like to have her hair colored. R9 further stated she had felt weak lately and hadn't wanted to	F 279		

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F 279	Continued From page 10 make the attempt to get up and get it done.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 1 of 1 resident (R19) who required a wanderguard, and 1 of 1 resident (R4) reviewed for timely positioning and incontinence care. Findings include: R19's care plan dated 6/30/14, indicated R19 wore a wanderguard to prevent injury from unknowingly leaving the building. On 9/30/14, at 9:05 a.m. the surveyor was unable to find the wanderguard bracelet on R19's ankles. On 10/1/14, at 7:55 a.m. R19 was observed not to have the wanderguard bracelet on her ankles. At 9:15 a.m. registered nurse (RN)-A checked R19 for a wanderguard bracelet and verified she not wearing one. On 10/1/14, at 8:53 a.m. RN-A verified the care plan was not followed regarding the use of the wanderguard.	F 282	Element 1 Residents R4 and R19 have been reassessed and their care plans have been updated as appropriate for repositioning, continence care, and wander guard use. The care plans have been implemented and communicated to the NARs via POC (point of care) kiosks throughout the facility. Element 2 A base line audit was performed on all residents who need repositioning, continence care, and/or are at risk for elopement. Care plans were updated as appropriate. The care plans have been implemented and communicated via POC kiosks located throughout the facility. Element 3 Accountability, communication and implementation of resident care plan interventions have been communicated via POC kiosks/paper documents and have been educated to nursing staff.	11/12/14

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F 282	Continued From page 11 R4's care plan dated 9/11/2014, indicated R4 was to be turned and repositioned every 1 1/2 hours when up in her wheel chair, and offered toileting every two hours. On 10/1/14, at 7:05 a.m. R4 was observed sitting at the dining room table. R4 was wheeled to the bathroom, and transferred with a mechanical lift onto the toilet at 9:25 a.m. On 10/1/2014, at 9:30 a.m. nursing assistant (NA)-H stated R4 was placed in her wheel chair at 6:30 a.m. and had not been repositioned or toileted since that time (2 hours and 55 minutes). NA-H stated R4 was to be repositioned and toileted every 2 hours. On 10/1/14, at 12:20 p.m. RN-A verified the care plan was not followed regarding repositioning and toileting. The undated care planning policy indicated an interdisciplinary team would develop and implement a comprehensive care plan that was individualized and designed to meet the needs of the resident.	F 282	Element 4 20% of resident care plan interventions will be monitored by the DON or designee for implementation daily x 7 days, then weekly x 4 weeks, then monthly for 1 month, and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	
F 309 SS=H	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		11/12/14

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F 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive assessment of pain, and failed to implement interventions in an attempt to manage chronic pain for 3 of 3 residents (R25, R6, R11) reviewed who experienced pain. Failure to alleviate pain resulted in actual harm for R25, R6 and R11. In addition, the facility failed to provide wheelchair positioning for 1 of 1 resident (R31) who had improper wheelchair positioning. Findings include: R25 was experiencing moderate to severe pain on a regular basis despite receiving narcotic pain medications and without adequate assessment of the pain. In addition, non-pharmacological interventions were not implemented to help alleviate pain. R25's significant change MDS dated 7/10/14, indicated R25 was cognitively impaired, understood others, had the ability to make self-understood and was able to express ideas and wants both verbally and non-verbally. The MDS indicated R25 required supervision with walking and dressing and was independent with eating. The MDS also indicated R25 received scheduled pain medication, received non-medical interventions, and had pain occasionally. The MDS identified diagnoses including: rheumatoid arthritis, chronic pain syndrome, osteoporosis, stage 3 kidney disease and transient ischemic attacks (TIA).	F 309	Residents R25, R6 and R11 were immediately effectively treated for pain and monitored around the clock. Comprehensive pain assessments were performed and analyzed. An interdisciplinary team form and new regimen have been created to address both pharmacologic and non-pharmacologic interventions to meet the individual resident□s pain goal. R31 was evaluated and provided a chair that meets positioning needs. Element 2 A comprehensive pain assessment was performed on all residents in the facility and care plans updated and implemented to meet all resident pain goals including pharmacologic and non-pharmacologic pain goals. All residents in wheel chairs were screened for proper positioning. Element 3 The pain protocol was updated to reflect current standards of care. Moderate to severe pain levels will be addressed immediately. Regular use of PRN pain medications will be evaluated for a more appropriate pain regimen. Education was provided to nursing staff. Therapy educated nursing staff on wheel chair positioning. Element 4 All residents will be evaluated for pain by nursing staff at least every shift on going.	

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F 309	Continued From page 13 The 7/24/2014, Pain Care Assessment (CAA) indicated R25 had arthritis and pain varied. R25's care plan last revised 8/5/14, indicated R25 rated her pain on a scale of 1-10 and as needed (PRN) medications may be given if indicated. Interventions indicated R25 was to participate in ambulation and exercises to decrease pain. No other pharmalogical interventions were addressed. The 6/12/2014, Pain Data Collection Assessment summary indicated R25 utilized a scheduled Fentanyl (narcotic medication) patch 25 micrograms (mcg) which was to be changed every 72 hours and Percocet 5/325 (narcotic medication to treat moderate to severe pain) milligrams (mg) PRN which was taken daily 4 out of 5 days. The assessment further indicated R25 had pain related to childhood rheumatoid arthritis, R25 participated in activities, ambulated to the toilet and also ambulated with staff. The assessment indicated the medication regimen was adequate for pain management and that staff should continue current care plan. The 6/25/14, therapy progress note indicated R25 was doing very well although ambulation distance varied due to pain in her legs, back, hands and neck from arthritis pain and directed the continuation of ambulation as tolerated. The 8/12/14, physician order indicated R25 was started on oxycodone (Percocet) 5/325 mg. one tablet every four hours PRN. The 9/2/2014, physician order indicated an increase of Fentanyl (Duragesic) to 50 mcg patch	F 309	DON or designee will monitor 20% of MARs for excessive PRN use and moderate to severe pain levels weekly x 4 weeks, then monthly for 2 months, and thereafter quarterly. DON or designee will monitor all residents in wheel chairs for appropriate positioning daily x 7 days, then weekly x 3 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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(previously 25 mcg) and to change every 72 hours for 30 days. The electronic medication administration record (EMAR) lacked monitoring and assessment of the efficacy of the increase in R25's Fentanyl patch.

The 9/15/14, physician note indicated R25 stated her legs hurt and indicated R25 had 2 plus peripheral edema bilaterally which she'd had for a long time. The note indicated the edema was a little worse and more uncomfortable for her. The note also indicated R25 had severe deforming rheumatoid arthritis. The physician's plan indicated R25 had not previously utilized diuretics, that the elevation of her legs was not taking care of the edema, and that it had become symptomatic for her. Plan to get a baseline BMP (basic metabolic panel- lab work) and another one on Friday and start her on Demadex (diuretic) 10 mg every day and to monitor weights.

The 9/24/14, nurse progress note by licensed practical nurse (LPN)-B indicated R25 had complained of severe left leg pain in the p.m. (evening), and that PRN Percocet 5/325 had been given at 4:40 p.m. and 10:30 p.m., with minimal relief after the 1st dose. The progress note indicated the nurse had noted R25's left leg was very swollen, from foot to hip. The record lacked documentation of the effectiveness of the 2nd dose of the PRN that had been given to R25.

The 10/2/2014, physician's order report indicated R25's current medications included: methotrexate sodium (used to treat severe rheumatoid arthritis) 25/ml (milliliters) injection every 7 days, Fentanyl patch every 72 hours 50 mcg/hr (hour), change every 3 days, Demadex 10 mg every day,

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Percocet 5/325 mg 1 tablet every 4 hours PRN, acetaminophen 325 mg two tablets PRN every 4 hours for minor or breakthrough pain and give between scheduled Percocet doses if needed. Do not exceed 3000 mg [acetaminophen] total in 24 hours.

The EMAR dated 9/2/14-10/2/14 revealed the following:

-R25's PRN Percocet had been used every day on average of 3 times a day and was up to 5 times in one day, with a total of 93 doses administered.

-PRN Percocet was given for bilateral pain for lower extremity discomfort.

-R25's PRN pain medication was effective 17 out of the 93 doses, "somewhat effective" 10 out of the 93 doses, not effective 1 out of the 93 doses, and 55 out of the 93 doses the effectiveness was lacking on the medical record.

During interview on 9/30/2014, at 7:42 p.m. R25 stated she had discomfort in both of her legs. Review of the EMAR indicated on 10/1/14, at 1:57 a.m. PRN Percocet 5/325 mg. one tablet was given due to left leg and right and left heel pain. Documentation on effectiveness was lacking.

During interview on 10/1/2014, at 7:05 a.m. R25 was observed lying in bed moaning "oh my leg hurts." Surveyor asked her if she had told anybody and she stated, "No, they know and all staff are busy." At 7:15 a.m. R25 stated both of her legs hurt, "they are hard as a rock, just feel them." At that time R25 removed her covers and showed the surveyor her legs that appeared shiny

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F 309	Continued From page 16 and firm to the touch. At 7:45 a.m. nursing assistant (NA)-D was observed assisting R25 wash up for the day. R25 stated her groin/crotch area was swelled up and so tight. At 7:50 a.m. R25 stated as she transferred from toilet to wheelchair, "oh my knees hurt." NA-D stated, "Oh that darn arthritis." NA-D handed her a pair of slacks and R25 started to put on the pants with NA-D's assistance. R25 stated, "ouch" then stated the pants were too tight. NA-D offered her 3 different pair of pants due to each pair being too tight. R25 moaned in discomfort as she attempted to put on each pair of pants. R25 stated, "My legs are bad." R25 added, "Oh it hurts me." NA-D stated at that time (8:00 a.m.) R25 usually dresses herself but that morning she needed help getting out of bed because of her leg discomfort. NA-D was not observed to notify the nurse of the pain. At 8:15 a.m. R25 stated her legs hurt and added, "They don't stop hurting." NA-D wheeled her to the dining room. On 10/1/14, at 8:27 a.m. LPN-A gave R25 PRN Percocet 5/325 mg. for pain. R25 rated her pain at an 8. At 8:50 a.m. R25 had finished eating her breakfast and at 9:00 a.m. R25 asked RN-A for a pain pill. LPN-A stated she gave her a pain pill 25 minutes ago and RN-A stated she should give the pain pill a while to work because she had just had her breakfast. At 11:25 a.m. NA-D stated R25 always had pain in her legs. NA-D stated it did not make a difference if she had taken a pain medication or	F 309		

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not, R25 was always in pain.

At 12:55 p.m. R25 stated,"[the pain pills] helped this morning for about two hours." R25 added, "They [her legs] hurt, they hurt, they hurt!"

At 1:05 p.m. R25 told the director of nursing (DON) her legs hurt. At 1:07 p.m. LPN-A gave PRN Percocet 5/325 mg. tablet for pain in her legs, rating the pain at a 9.

On 10/1/14, at 1:07 p.m. LPN-A stated staff can tell if R25's pain pills were effective or not, staff don't ask R25 if the PRN pain pills were effective because that was "like planting in her the need for another pain pill." LPN-A stated staff wait for her to ask for another pain pill. LPN-A stated NA-D did not inform her that R25's legs hurt on the morning of 10/1/14. LPN-A stated NA-D should have reported to her and R25 should have had a pain pill before getting out of bed. LPN-A added, "It has been very crazy around here." LPN-A stated R25 did not receive the PRN acetaminophen for breakthrough pain probably due to the staff did not want R25 to exceed the recommended amount of 3000 mg, since Percocet also has acetaminophen.

On 10/2/14, at 9:30 a.m. LPN-B stated R25 was doing terrible with her pain management for her legs. LPN-B stated the medications did not seem to help. LPN-B stated she had not been giving R25 the PRN acetaminophen for break through pain and did not know why they did not give it.

On 10/2/14, at 9:30 a.m. registered nurse (RN)-B stated NA-D should have contacted LPN-A

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regarding R25's pain and before starting a.m. cares. RN-B verified R25 had used PRN Percocet 2-3 times a day and she questioned if it should be given on a regular basis. RN-B stated the physician would be contacted and verified the break through PRN acetaminophen should be given as directed by the physician. RN-B stated the staff could be doing some monitoring of R25's pain on a daily basis for the effectiveness of her current pain medications. RN-B added if staff were reporting that R25's pain was terribly managed, the information needed to be relayed to the DON.

On 10/2/14, at 11:20 a.m. LPN-B stated R25's PRN Percocet usually was effective for a while but then R25 would state, "Old Arthur hurts." LPN-B stated last night LPN-D gave R25 a PRN Percocet around 2:00 a.m. and then 2 hours later R25 was asking for another pain medication, however, did not give her anything.
LPN-B stated due to the fact R25 was on the bumped up dose of Duragesic patch, staff were concerned about her being a fall risk because she did get up by herself.

On 10/2/14, at 11:55 a.m. the DON and RN consultant were interviewed. The DON stated the break through PRN acetaminophen needed to be implemented as directed by the doctor.

On 10/2/14, at 2:30 p.m. RN-B provided the surveyor with a physician order dated 10/2/14, indicating R25 was to have an X-ray of bilateral hips, make appointment with physician to see if resident qualified for steroid injection in hips- left was worse than right, to schedule Tylenol 325 mg 2 tabs by mouth three times a day, ace wraps to lower extremities, and to increase Demedex to 15

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F 309	Continued From page 19 mg every day. R6 was experiencing chronic pain on daily basis which affected her ability to participate in activities of daily living, without adequate assessment of the pain and/or efficacy of the narcotic medication. In addition, non-pharmacological interventions were not implemented to help alleviate pain. R6's annual MDS dated 3/3/14, indicated R6 had intact cognition and required extensive staff assistance for all activities of daily living. The MDS also indicated during the annual assessment period, R6 had reported her pain level at a 5 on a 0 to 10 pain scale. The assessment indicated the pain limited R6's ability to participate in day to day activities. R6's Pain CAA dated 3/13/14, indicated R6 voiced complaints of leg pain daily. R6 was on scheduled pain medications and received PRN medication for break through pain. R6's pain was attributed to cerebral palsy, muscle dystrophy and muscle spasms. The CAA also indicated staff assisted her to take frequent rest periods throughout the day and to keep the physician informed of the pain management program. R6's quarterly MDS dated 9/3/14, also indicated R6 had intact cognition, required extensive staff assistance with all activities of daily living and was unable to ambulate. The MDS indicated R6 had diagnosis including cerebral palsy, anxiety, diabetes mellitus and congestive heart failure. The MDS also indicated R6 suffered from frequent pain which prevented her from participating in daily activities. During the	F 309		

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F 309	Continued From page 20 assessment period, R6 had reported her pain to be at a 6 on a 0-10 pain scale. R6's care plan dated 6/4/14, identified an alteration in comfort related to numbness/tingling in the hands secondary to carpal tunnel syndrome and muscle spasticity secondary to cerebral palsy. The plan directed staff to anticipate her needs and respond in a timely manner. The care plan did not direct staff on how to minimize potential leg pain and it did not include non-pharmacological interventions to minimize R6's pain. The physician note dated 7/3/14, indicated R6's biggest problem was related to pain control. The note also indicated at that time, R6 was watching the clock and asking for frequent pain medications. The physician had initiated use of a Fentanyl patch for R6 and indicated the staff were to monitor for pain control and anxiety related to the pain medications. The physician identified a plan to continue to make pain medication changes if this was not effective. R6 was seen by the physician on 8/5/14, 8/8/14 and 8/12/14, for an acute infection, those progress notes did not address R6's pain. During a visit on 9/5/14, the physician noted, "Will continue with her current pain medications, which are working pretty well for her." The Physician Order Report dated 9/5/14, included Baclofen (muscle relaxer) 10 mg three times a day, Gabapentin (medication used to treat nerve pain) 300 mg three times a day, and Tylenol extra strength 500 mg one tablet every four hours as needed for pain. In addition, on	F 309		

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F 309	Continued From page 21 7/6/14, the physician had added Fentanyl (medicated pain patch) 25 mcg/ hour to be changed every three days. The facility completed a Pain Data Collection for R6 on 8/30/14 - 9/3/14, 5/31/14 - 6/4/14, 2/27/14 - 3/31/14, and 11/27/13 - 12/1/13. The data collection tools indicated R6 experienced pain daily. After each pain data collection period the registered nurse completed a review of R6's pain. The summary repeated the current pain medications, indicated R6 had voiced concerns of pain daily and directed staff to assist with comfort via as needed pain medications, repositioning, occupational and physical therapy interventions. However, the summaries did not address R6's response to the current medication regimens. In addition, the clinical record lacked indication whether the addition of the Fentanyl patch started on 7/6/14, was effective. Review of the resident progress notes (nurse's notes) indicated the following information: - 7/10/14, at 3:29 a.m. R6 was complaining of pain more frequently this shift. She is currently on Tylenol prn which she had received at 6:00 p.m. and 11:23 p.m. R6 continued to holler out and request pain pill frequently (every 15 minutes) throughout the night shift. R6 was repositioned with relief lasting 15-30 minutes before she would request additional medications. -7/17/14, at 3:33 a.m. R6 received Tylenol 500 mg at 3:00 am. R6 complains of pain responds well to repositioning and massage as non-pharmacological therapy. - 7/31/14, at 2:57 a.m. R6 had Tylenol 500 mg at	F 309		

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F 309	Continued From page 22 1:30 a.m. Non-pharmacological interventions used before resident was due for PRN included light massage, reposition and range of motion with the affected leg. -8/17/14, at 5:11 a.m. R6 requested Tylenol one time. No further follow up was noted. - 8/28/14, at 6:41 a.m. R6 received Tylenol 500 mg for leg pain. The note lacked follow up to the pain. On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh." No staff members were observed in the dining room as R6 cried holding her head. A few moments later NA-A walked up to R6 and escorted her to her room. At 9:15 a.m. R6 was observed resting in bed. On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head. At 9:05 a.m. NA-A wheeled R6 to her room. At 9:10 a.m. NA-A stated R6 cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication. On 10/2/14, at 9:45 a.m. R6 stated she	F 309		

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experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain as a "toothache that never goes away." She stated the pain prevented her from participating in many of the activities in the facility because sometimes it was better in the chair... and other times it was better in bed. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is receiving her pain medications.

On 10/2/14, at 10:00 a.m. NA-D stated R6 expressed pain in her left leg every day. She stated she attempts to reposition R6 in bed or rub her leg, but it usually does not give R6 extended relief. She stated R6 may have a few moments of pain relief, but it did not last long. She reports the pain to the nurses.

Review of the EMAR revealed the following information:

7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol.

7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol.

8/1/14 - 8/31/13, R6 received 81 doses of PRN Tylenol 500 mg.

9/1//14 - 9/30/14, R6 received 98 doses of PRN Tylenol 500 mg.

10/1/14- 10/2/14, R6 had received 6 doses of

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F 309	Continued From page 24 PRN Tylenol 500 mg. The reason documented for the medication was "pain" or "leg pain." The medication was noted to be "effective" or "somewhat effective." On 10/2/14, at 10:10 a.m. LPN-B stated R6 reported complaints of pain "all of the time." She stated R6 will request pain medications and will watch the clock waiting for the four hours to pass before she can ask for the next pill. LPN-B stated R6 was uncomfortable, "I wish we could find something to giver her relief." LPN-B stated when she would administer R6's pain medications she followed up with R6 by visually looking at her. She stated if the nurse were to ask her how her pain was, she would just ask for more medications. LPN-B added if R6 looked like she was not in pain, they write effective or somewhat effective. She confirmed she did not discuss pain relief with R6. On 10/2/14, at 11:00 a.m. R6's pain was reviewed with the interim DON and the consultant RN. The interim DON stated she was aware R6 expressed pain daily. The two RNs reviewed R6's clinical record and were unable to find indication in which the staff had completed a comprehensive assessment of R6's pain and were unable to determine if the Fentanyl which had been added in 7/2014, was an effective medication for controlling the pain. On 10/2/14, at 11:20 a.m. the consultant RN confirmed R6 experienced pain daily and had not been comprehensively reassessed by the nurses to determine the extent of the pain. She stated the facility had not exhausted resources to reduce	F 309		

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F 309	Continued From page 25 R6's pain. She confirmed R6 had not consistently received non-pharmacological interventions to minimize pain and she continued to express pain. She stated she was aware R6 was utilizing PRN medications for the treatment of pain but was not aware she was utilizing over 70 PRN medications per month. At that time the RN consultant was asked to review R6's medication regimen to determine a timeline of pain medication changes in the past 6 months. On 10/3/14, at 8:50 a.m. the consultant RN stated she had interviewed R6 and confirmed R6 expressed continued pain. She stated she did not find it helpful to review R6's record to determine what had been attempted in the past, but felt it was better to take the time and move forward and treat R6's pain. The consultant RN provided a Patient Comfort Assessment Guide dated 10/3/14, which confirmed R6 continued to express daily pain. R11 was experiencing moderate to severe chronic pain on daily basis which affected her ability to participate in activities of daily living without adequate assessment of the pain and / or efficacy of the narcotic medication nor consistent implementation of non-pharmacological interventions to help alleviate the pain. R11's Physician Order Report dated 9/3/14-10/3/14, indicated R11 had diagnoses that included osteoporosis (a disease in which bones become fragile and more likely to fracture), lower leg osteoarthritis (degenerative arthritis affecting the cartilage), chronic pain, restless leg syndrome and Wegener's granulomatosis (causes inflammation of the blood vessels).	F 309		

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F 309	Continued From page 26 R11's significant change MDS dated 8/11/14, indicated R11 had severe cognitive impairment and required extensive assistance of one staff for locomotion on and off the unit, dressing and personal hygiene and limited assistance of one staff for bed mobility, transfer, ambulating in room and corridor and toilet use. The MDS also indicated R11 received scheduled and as needed pain medication and non-medication interventions for pain. The MDS also indicated R11 reported her pain as moderate and frequent but it did not interfere with daily activities or make it difficult to sleep at night. The MDS further indicated R11 received physical therapy (PT) and occupational therapy (OT) services and received active range of motion (ROM) restorative nursing services. R11's quarterly MDS dated 7/12/14, indicated R11 had moderate cognitive impairment and required limited assistance of one staff for bed mobility, transfers, dressing and toilet use and supervision of one staff for ambulating in room or corridor, locomotion on and off the unit, and personal hygiene. The MDS also indicted R11 received scheduled and as needed pain medications and non-medication interventions for pain. The MDS also indicated R11 reported her pain as moderate and frequent but it did not interfere with daily activities or make it difficult to sleep at night. The MDS indicated R11 did not receive PT, OT or restorative nursing services. R11's pain CAA dated 8/23/14, indicated R11 remained at risk for ongoing pain, increase in pain and unrelieved pain due to debilitating effects of chronic disease. The CAA indicated R11 reported pain to lower back, knees and joints and described it as an "achy, arthritic pain,"	F 309		

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F 309	Continued From page 27 remained alert and able to communicate needs effectively and appropriately and could alert staff if and when in pain. The CAA indicated staff was to observe and report any non verbal indicators of pain. Finally, the CAA indicated R11's pain was chronic in nature and required scheduled and PRN analgesics to maintain optimal comfort level. R11's Activities of Daily Living / Functional Rehabilitation CAA dated 8/23/14, indicated R11 remained at risk for further on going decline due to progression of chronic disease processes resulting in a past history of falls, chronic pain and functional urinary incontinence. The CAA indicated R11 had returned to baseline since hospitalization for pneumonia and indicated staff was to continue to assist with ADL and mobility as needed and report changes in ability and tolerance. The CAA also indicated anticipation of on going fluctuation of physical function and tolerance based on potential exacerbation of chronic disease processes. R11's care plan dated 7/17/14, identified R11 had alteration in comfort related to pain secondary to history of compression fractures of her back and indicated R11 would verbally state pain was 2-3 on a verbal scale of 0-10 after administration of pain medication. The care plan directed staff to administer medications as ordered for pain and to monitor for effectiveness of pain medications and possible side effects. The care plan did not identify or address R11's knee/joint pain, nor did it identify non-pharmacological interventions for pain.	F 309		

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F 309	Continued From page 28 Review of R11's medical record revealed the following history regarding the ongoing management of R11's knee pain: The RN Assessment Summary dated 1/13/14, on the Pain Data Collection form dated 1/8/14, to 1/12/14, indicated R11 had denied pain during the assessment period and R11 received scheduled Lortab (hydrocodone-acetaminophen)(a narcotic pain reliever for moderate to severe pain) 10-500 mg three times daily and Lidoderm patch (a local anesthetic) to lower back daily. It also identified R11 could also have PRN Lortab for breakthrough pain though she had not received any during the assessment period. Non-medication interventions to pain included repositioning, exercise/ROM, activities and 1:1 visits. R11's pain was assessed as controlled with medication and interventions at that time. The physician progress note dated 2/25/14, identified R11 had a chief complaint of right knee pain with weight bearing for 1 week. It also identified R11 had a history of degenerative joint disease and R11 had last had an injection months previous that had helped "for a long time." The progress note further indicated R11 received a cortisone injection to her right knee at the visit. The physician progress note dated 3/10/14, indicated the visit was for follow up on R11's right knee pain and identified R11 reported some relief of that pain with the cortisone injection but not for very long. R11 continued to report pain with weight bearing and stated it hurt even while in bed at times. The progress note also identified	F 309		

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F 309	Continued From page 29 R11 had been taking Lortab on a scheduled and PRN basis. R11 reported the medication worked for a while but wore off. The physician assessment identified right knee pain with degenerative joint disease, transient response to cortical steroid injection with constipation likely related to activity and pain medications. The progress note identified the physician's plan was to increase R11's laxatives and switch her to a Fentanyl patch from scheduled hydrocodone, 12.5 micrograms (mcg) per hours equivalent to her current dose of 30-40 mg per day of hydrocodone. The physician's telephone orders dated 3/10/14, included the following: change Lortab 10-500 to Norco (hydrocodone-acetaminophen)(a narcotic pain reliever for moderate to moderately severe pain) 5-325 mg one by mouth three times a day as needed, trial of Fentanyl patch 12.5 mcg change every 3 days and discontinue scheduled Lortab. The RN Assessment Summary dated 4/13/14, on the Pain Data Collection form dated 4/7-4/11/14, R11 had reported pain almost daily during the look back period and identified R11 was on scheduled pain medication and took PRN medication frequently with effective results. The summary also indicated R11 was encouraged to ambulate and be as active as possible and during this time a knee brace being worn was discontinued due discomfort. The summary further identified R11 had a recent pain medication change which seemed more effective.	F 309		

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F 309	Continued From page 30 The Memo To Physician dated 4/18/14, identified R11 was needing to take her PRN Norco three times a day nearly each day and still complained of pain. The memo asked if the medication could be given more often for R11's breakthrough pain. The physician response dated 4/21/14, was an order for Norco three times per day with Norco twice a day PRN for breakthrough pain. The Memo to Physician dated 6/1/14, identified R11 appeared to be more drowsy and lethargic and questioned confusion. The memo asked if they could consider going back to increased dose of Vicodin (hydrocodone-acetaminophen) or oral morphine versus Fentanyl. The memo indicated R11's family had concerns with Fentanyl and wanted the physician to consider MS Contin (time-released morphine usually taken every twelve hours for chronic pain) and an increase of R11's Norco back to 10-325 [sic] four times a day and twice a day as needed. The physician response dated 6/12/14, indicated "we'll see how she responds to increased Zoloft" (an antidepressant). The Nursing Home Note dated 6/12/14, identified R11 was seen for bilateral hearing loss and indicated mood wise R11 still had some dysphoria. R11 was not sure if this was related to vision and hearing issues or just mood. The note identified R11 was on 12.5 mg per day of Zoloft that was helping. The note also identified there had been some concern about increasing confusion and there had been some discussion about switching back from Fentanyl to Norco. The note further identified R11 had only taken 3 PRN Norco in the past 2 weeks while on the	F 309		

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Fentanyl. The physician's impression was some concern for intermittent confusion and indicated he would hold off on the Fentanyl change at that time. The impression also indicated a possible mood issue and the physician increased her Zoloft from 12.5 to 25 mg per day.

The Nursing Home Note dated 7/8/14, indicated R11's family was very concerned her decline in status might be related to medications, specifically Fentanyl. The physician impression indicated he felt R11's mental status changes were possibly related to depression and likely related to her vision and hearing loss. The physician's plan was to lower gabapentin (for restless leg syndrome) from four times a day to twice a day and hold R11's Fentanyl. The physician indicated morphine was an option down the road if R11 did well off of the hydrocodone. Other options identified were discontinuation of gabapentin altogether or increase or decrease of R11's Zoloft dose.

The Physician's Telephone Orders dated 7/8/14, included decrease gabapentin to 300 mg twice day and hold Fentanyl patch trial for one week.

The RN Assessment Summary dated 7/14/14, on the Pain Data Collection form dated 7/8/14 -7/12/14, identified R11 reported moderate pain daily and indicated the physician was trying to balance pain control and symptoms of confusion. The RN repeated the current pain medication regimen and indicated they would continue to work with the physician for pain control. The assessment did not identify non-pharmacological

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F 309	Continued From page 32 interventions for pain. The Physician's Telephone Orders dated 7/15/14, discontinued gabapentin and discontinued Fentanyl patch. The Nursing Home Note dated 7/29/14, indicated R11 was seen regarding family concerns related to pain, delirium, hearing and intake issues. The physician's impression included pain issues with vertebral compression fractures and arthritis. The physician's plan identified R11's family was wondering about morphine. The physician indicated he was considering a referral to hospice for their advice. His plan further indicated he would not change medications until R11's shortness of breath (identified upon physician examination) was evaluated. R11 was hospitalized from 7/31/14, through 8/4/14 for pneumonia. The facility completed Pain Data Collection for R11 on 8/5/14 - 8/9/14. The RN assessment summary of the data collection completed on 8/13/14, identified R11 had complained of pain during the assessment period. The RN repeated the current pain medication regimen and indicated R11's pain was rated as mild and the current regimen was meeting R11's needs. The assessment summary did not address non-pharmacological interventions for pain. The Physician Order Report dated	F 309		

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9/3/14-10/3/14, included orders for Lidoderm adhesive patch 5% mg/patch), apply 1 new patch topically to mid-back daily on 12 hours and off 12 hours for chronic pain, Norco 5-325 mg three times a day (scheduled dose), Norco 5-325 mg 1 tab twice a day PRN for pain, and acetaminophen 500 mg 1 tab every 6 hours PRN for pain. The report also included an order for heat or ice to right knee for comfort as needed on for intervals of 10 minutes with a start date of 3/17/14.

The Nursing Home Note dated 10/1/14, indicated R11 was seen by the nurse practitioner for right knee pain. R11 reported discomfort with walking. The nurse practitioner's plan was to apply ice or alternate heat and ice, continue with pain medications on the MAR (medication administration record) and participate in activities as tolerate.

R11's Medication Administration History dated 8/8/14 -10/3/14 revealed:

-Lidoderm adhesive patch 5% was administered early at R11's request 30 of 57 days.

-Norco 5-325 mg three times a day (scheduled dose) was given early for the morning dose on 8/25, 9/12, 9/22, 9/25, 9/26, 9/29, 9/30, 10/1, 10/2, and 10/3 and for the afternoon dose on 9/9 (11 doses).

R11's PRN Medications Administration History 8/8/14-10/3/14 revealed:

-Norco 5-325 mg 1 tab twice a day PRN, 32 doses were given on 29 of 57 days for complaints of pain in knees or legs. 24 of 31 doses were given between the hours of 12:55 a.m. and 4:52

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F 309	Continued From page 34 a.m. 4 doses were given between the hours of 9:42 a.m. and 2:29 p.m. and 3 doses were given between the hours of 11:01 p.m. and 11:31 p.m. The medications were assessed to be effective or somewhat effective except for one dose given on 9/28 which was assessed to be not effective and R11's next scheduled dose of Norco was given early. -acetaminophen 500 mg 1 tab every 6 hours as needed was given once on 8/8, 8/30, and 9/3 and given three times on 10/2 for complaints of pain in knees or legs. The medications were assessed to be effective R11's Treatment Administration History 8/8/14-10/3/14 revealed: -Heat or ice to right knee for comfort as needed for intervals of 10 minutes was not documented on the treatment record during this time period. The resident progress note dated 10/1/14, at 11:23 p.m. indicated an ice pack was applied to R11's right knee two times during the shift. R11 stated, "It feels better" however, within 1-2 hours complained of breakthrough pain. On 10/2/14, at 9:04 a.m. R11 was observed in her room seated in a recliner. R11 stated she had been having a lot of problems with her right knee and raised her pant leg above her knee and began to rub it. The knee was observed to be swollen. R11 stated she was given pain pills for the knee pain and that they lasted a little while "but they don't last forever." She stated that on 10/1/14, she was given cold packs, as well, and that helped for a little bit. R11 stated the pain	F 309		

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F 309	Continued From page 35 kept her up at night at times and that the previous night she was "up a lot" until she finally got a pain pill. R11 stated the pain medication lasted for about 4 hours before her knee began hurting again. R11 also stated she asks for a pain pill a couple of times a day and identified her pain at that time at an 8 out of 10. R11 stated she also received cortisone shots from the physician and they lasted for about a month but the pain always came back. R11 further stated she was due for her bath today and the whirlpool tub also felt good on her knee. On 10/02/2014, at 9:36 a.m. R11 was observed ambulating down the hall with wheeled walker from her room to the bath room. Her gait was slow and R11 was observed to favor her right side. On 10/02/2014, at 10:02 a.m. R11 was observed ambulating back toward her room after her bath. R11 was observed to be limping on her right leg. R11 stated her knee felt much better after her whirlpool bath. On 10/2/14, at 10:43 a.m. R11 was observed seated in her room in a recliner with a wheeled walker in front of her chair. R11 stated the pain limited her activities during the day and prevented her from joining in. She stated, "I just can't do it." R11 stated her knee currently still ached and was a 7 out of 10 on a 1 to 10 pain scale. R11 stated her knee hurt all the time but it was alright if she sat "absolutely still." R11 further indicated walking made her knee feel worse.	F 309		

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F 309	Continued From page 36 On 10/02/2014, at 10:48 a.m. NA-B stated R11 had pain daily and may have had more pain lately since recently bumping her right knee. NA-B indicated R11 would go to some activities if she felt up to it and attended therapy [restorative nursing] three times a week and would tell them if her right knee bothered her too much so they then did not do exercises on that leg. On 10/02/2014, at 10:55 a.m. NA-D stated R11 had pain every day and received pain medication for the pain. NA-D indicated she was not aware of any non-pharmacological interventions for the relief of R11's pain nor was she aware of factors that aggravated R11's pain. NA-D stated R11 spent most of her time in her room and only came out for meals or a bath. NA-D also stated R11's family used to bring her out to the common area to visit and have coffee, however they no longer did this when they visited. NA-D further indicated R11's pain was mostly in her knees. On 10/02/14, at 11:05 a.m. NA-C stated she worked with R11 with restorative nursing exercises to both upper and lower extremities. NA-C confirmed R11 had pain in her right knee. Review of the restorative nursing sheets for August 2014, and September 2014, revealed R11 had not refused exercises to the right lower extremity. On 10/02/2014, at 2:39 p.m. licensed practical nurse LPN-B stated R11 received scheduled pain medication three times a day and could also have PRN pain medication for her knee pain. She	F 309		

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stated if R11 asked for extra pain medication, it was usually needed on the night shift but was occasionally given during the day. LPN-B stated PRN Norco was usually given. LPN-B stated she did not specifically ask R11 how effective the pain medication was or asked R11 to rate her pain using the 1-10 pain scale after medication was given. LPN-B stated sometimes asking a resident about pain medication would prompt them to ask for additional medication. LPN-B stated instead she would simply observe for effectiveness or have general conversation with R11 and see if she complained of further pain. LPN-B indicated R11 had used warm packs on her legs before but stated they had only done so very occasionally and it had been about a month since the warm packs had been used. LPN-B indicated that the warm packs had been effective and R11 had liked the warm packs when used in the past. When asked why they stopped used warm or cold packs for R11's knee pain, LPN-B stated "sometimes you get complacent". LPN-B indicated that currently if R11 indicated she was in pain and had just had a pain pill, they instructed her to elevate her legs and take it easy until the medication worked. Additionally, LPN-B stated R11 stayed in her room quite a bit, but came out occasionally for activities.

On 10/02/2014, at 3:12 p.m. interim DON and consultant RN confirmed hot/cold packs should have been used as a non-pharmacological intervention for R11's knee pain and R11's pain should have been reassessed upon her return to baseline functional ability after her hospitalization.

On 10/3/13, at 8:55 a.m. the consultant RN

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F 309	Continued From page 38 provided a Patient Comfort Assessment Guide dated 10/3/14 which confirmed R11 continued to express continuous pain that only went away with pain medication. The facility's undated Pain Assessment Policy, directed staff to assess the resident's pain level and provide optimal comfort through a pain control plan which was mutually established with the resident, family and members of the health team. The policy directed the staff to assess the resident's pain, develop pharmacological and non pharmacological interventions to reduce the pain and to contact the physician of any unrelieved pain. R31 was not provided leg rests on the wheelchair to ensure appropriate positioning. R31's admission MDS dated 8/23/14, indicated R31 was cognitively intact, was independent with wheelchair locomotion, transferring and was non-ambulatory. R31's Fall CAA dated 8/23/14, indicated R31 had a puncture wound on her left foot, was non- weight bearing and could safely transfer self from the bed to the wheelchair and back. On 9/29/14, at 6:10 p.m. R31 was observed in her wheelchair self propelling with her hands. R31's feet were observed dangling unsupported about eight inches from the floor. There were not leg rests observed on the wheelchair. On 9/30/14, at 8:46 a.m. R31 stated they did not provide her with wheelchair leg rests.	F 309		

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At 2:26 p.m. R31 was observed self propelling her wheelchair with her hands. Her left foot was in a walking boot and her right foot was about eight inches from the floor.

At 2:56 p.m. R31 was observed self propelling herself in the wheelchair back to her room. R31 was able to use her left foot that was in the walking boot to help with propelling. R31's toes of her right foot were observed to touch the floor. The wheelchair was not equipped with leg rests.

At 3:45 p.m. R31 was observed in her wheelchair at a table playing a game. Her right heel remained unsupported and dangling about eight inches from the floor.

On 10/1/14, at 8:10 a.m. R31 was observed in her wheelchair. R31 had a blue surgical bootie on her left foot dressing and a sock on her right foot. R31's feet were observed unsupported and dangling about eight inches from the floor.

At 8:20 a.m. registered nurse (RN)-A stated R31 was admitted in a wheelchair. RN-A stated neither physical therapy (PT) or occupational therapy (OT) had seen R31. RN-A stated R31 was so independent with self propelling her wheelchair with her hands. RN-A stated she had not noticed that R31's feet did not touch the floor.

At 11:20 a.m. R31 stated the first wheelchair she had was equipped with leg rests and that chair was too wide for her to get into the bathroom. At this time OT-A stated R31 was up "way too high." OT-A stated her feet were eight inches from the floor. R31 stated she only used her hands to propel the wheelchair. OT-A told R31 they did not

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F 309	Continued From page 40 want her feet to dangle from the wheelchair. OT-A stated he would make wheelchair adjustments for proper wheelchair positioning. At 11:27 a.m. R31 stated since her first wheelchair was too wide for her, family member (FM)-A found this current wheelchair in the hallway and gave to her to use about two weeks ago. On 10/2/14, at 8:21 a.m. nursing assistant (NA)-C stated if she were to see a resident that did not have proper wheelchair positioning she would notify OT. NA-C stated she had not worked for the past 3 weeks. At 9:17 a.m. the consulting registered nurse (RN) stated there was not a policy related to proper wheelchair positioning .	F 309		
F 314 SS=D	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 received	F 314	Element 1 A tissue tolerance was performed on R4 and the pressure ulcer prevention care	11/12/14

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F 314	Continued From page 41 assistance with repositioning in order to prevent the development of pressure ulcers for 1 of 1 resident (R4) in the sample. Findings include: R4's diagnoses included a multiple sclerosis, cerebral palsy, stroke, and diabetes, according to the electronic medication administration record (EMAR). The quarterly Minimum Data Set (MDS) dated 9/6/2014, indicated R4 had cognitive impairment, required extensive assist from staff for bed mobility, transfers, and was non ambulatory. The MDS also indicated R4 was at risk for pressure ulcers. The 3/6/14, Pressure Ulcer Care Area Assessment (CAA) also indicated R4 was at risk for pressure ulcers due to incontinence and non-ambulatory. The care plan dated 9/11/2014, indicated R4 was to be turned and repositioned every 3 hours while in bed and 1 1/2 hours when up in her wheel chair due to risk for pressure ulcers. The care plan R4 had a pressure reducing cushion in her wheel chair. The 9/17/14, Braden Tissue Tolerance assessment indicated R4 was at risk for pressure ulcers due to immobility and incontinence. On 10/1/14, at 7:05 a.m. R4 was observed sitting in the dining room at the table. At 7:30 a.m. R4's	F 314	plan was updated to reflect current standards of care. The resident remains at base line without skin breakdown. Element 2 All residents at risk for skin breakdown were reassessed for bed, wheelchair, and general positioning and tissue tolerance. The care plans were updated as necessary and implemented/communicated per POC kiosks throughout the facility. Element 3 Pressure ulcer prevention protocol was updated as appropriate and educated to nursing staff. Element 4 Residents dependent for bed,wheelchair, and general positioning will be monitored for repositioning by the nurse on duty daily. The DON/designee will audit weekly x 4 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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F 314	Continued From page 42 son stated she had been up in the chair when he came to see her at 6:45 a.m. From 7:50 a.m. to 8:50 a.m., R4 was observed to continue sitting at the table in the dining room. At 8:50 a.m. R4 finished her breakfast. At 9:25 a.m. R4 was wheeled to the bathroom and transferred to the toilet. R4's skin to the buttocks was observed intact with slight redness. On 10/1/2014, at 9:30 a.m. when asked by surveyor, NA-H stated R4 was placed in her wheel chair at 6:30 a.m. and had not been repositioned or toileted since that time (2 hours and 55 minutes without repositioning). NA-H stated R4 was to be repositioned and toileted every 2 hours. On 10/1/14, at 12:20 p.m. registered nurse (RN)-A verified R4 was to be repositioned every 1 1/2 hours while in her wheel chair. Adding R4's care plan was not followed.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration,	F 322		11/12/14

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F 322	Continued From page 43 metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer medications via gastrostomy tube (G-tube) individually with appropriate water flushes for 1 of 1 residents (R33) who received G-tube medications Findings include: R33's Physician Order Report dated 8/5/14-10/14/14 identified diagnoses that included post concussion syndrome and gastrostomy (creation of an artificial external opening into the stomach for nutritional support or gastrointestinal compression). During observation on 10/01/14, at 11:35 a.m. licensed practical nurse (LPN)-A dispensed an aspirin 81 milligram (mg) chewable tablet into a paper medication cup. She then measured 30 milliliters (ml) of lactulose solution 20 gram (gm)/30 ml into a plastic medication cup. LPN-A then dispensed a hydrocodone-acetaminophen 5-325 mg tablet into the paper medication cup with the aspirin. Finally, LPN-A drew 4 ml of potassium chloride 10% 20 milliequivalents (meq)/15 ml solution into a 10 ml syringe. LPN-A then placed the tablet medications into a plastic	F 322	Element 1 The nurse who did not flush the G-tube with water between individual medications was educated regarding the correct policy regarding flushing with water between individual medications and return demonstration was verified. Element 2 All residents with G-tubes were assessed during medication pass for correct method per policy regarding flushing with water between individual medications. Element 3 The policy was reviewed and updated as appropriate. Licensed nurses were educated about the policy regarding flushing between individual medications when providing medications per G-tube. Element 4 The DON/designee will audit medication administration according to policy for all residents with G-tubes daily x 7 days, then weekly x 3 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the	

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F 322	Continued From page 44 sleeve and crushed the medications, placed the crushed medications into a plastic water glass, and added 15 mls of warm water to dissolve the medications. LPN-A gathered the medications and gloves and entered R33's room. LPN-A donned the gloves and drew air into a 60 ml syringe. LPN-A stopped the tube feeding and checked the placement of the G-tube by listening as she instilled air into the G-tube. LPN-A then drew 30 mls of water into the 60 cc syringe and flushed the G-tube. Next, she drew lactulose into the syringe and instilled 1/2 the solution into the G-tube. LPN-A then drew 10 ml of water into the syringe with the remaining lactulose and instilled via the G-tube. LPN-A flushed the G-tube with 15 mls of water. Next, LPN-A drew the crushed medication and water solution into the syringe and instilled by depressing the plunger. She then flushed the G-tube with 15 ml of water. Next LPN-A squirted the potassium solution from 10 ml syringe into the plastic water glass and drew it into the 60 ml syringe, and instilled it into the G-tube. Finally, LPN-A flushed the G-tube with 30 ml water and restarted the feeding. LPN-A discarded her gloves, raised the head of R33's bed and washed her hands before exiting the room. R33's Physician Order Report dated 8/5/14-10/15/14 directed staff to flush G-tube with 30 ml of water before and after each medication. The order did not direct the mixing of medications. On 10/01/2014, at 11:51 a.m. LPN-A stated that pharmacy had told them they could crush and give oral medications together. LPN-A stated she had not been instructed to give each medication separate with flushes between.	F 322	Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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F 322	Continued From page 45 On 10/03/2014, at 9:32 a.m. the consulting registered nurse (RN) indicated the facility had been instructed by pharmacy to either flush between each medication or flush before and after a group of medications as long as there are no incompatibilities between the medications given concurrently. On 10/03/2014, at 11:34 a.m. the consulting RN confirmed the physician orders called for 30 ml flush between each medication. The Enteral Tube Medication Administration policy date 4/23/14, directed crushed medications were not to be mixed together. Each medication was to be administered separately to avoid interaction and clumping. The enteral tubing was to be flushed with at least 5 ml of water between each medication to avoid physical interaction of the medications.	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to apply a wanderguard bracelet for safety for 1 of 1 residents (R19)	F 323	Element 1 A wander guard was placed on resident R19 who is identified as an elopement	11/12/14

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F 323	Continued From page 46 identified as wandering outside facility unsupervised. Findings include: R19's annual Minimum Data Set (MDS) dated 12/26/13, indicated R19 had severe cognitive impairment. The nursing progress notes dated 8/10/14, (late entry for 8/9/14), noted R19 followed someone outside to the patio and her wanderguard alarm did not sound. R19's ankles were checked and there was no wanderguard present. A new wanderguard was placed. R19's treatment flowsheet for October 2014, read WANDERGUARD ON AT ALL TIMES INDICATED FOR MEMORY LOSS AND HIGH MOBILITY. There was no staff initial to indicate the wanderguard was being checked for placement on a daily basis. It indicated for your information (FYI). R19's care plan dated 6/30/14, indicated R19 wore a wanderguard to prevent injury from unknowingly leaving the building. On 9/30/14, at 9:05 a.m. the surveyor was unable to find the wanderguard bracelet on either of R19's ankles. At 10:58 a.m. R19 was seated in a rocking chair in the living room. At 11:04 a.m. R19 ambulated down the north hallway. At 2:17 p.m. R19 was seated in the rocking chair in the living room. No wanderguard bracelet was observed on R19's ankle during these observations. On 10/1/14, at 7:55 a.m. R19 was observed not to have the wanderguard bracelet on her ankles.	F 323	risk. Nurses are checking placement of the wander guard every shift per the MAR. Element 2 A baseline audit of all residents who are elopement risks were assessed for placement of wander guards. All residents wander guard placement is being checked by nursing ever shift per the MAR. Element 3 The policy was reviewed and updated as appropriate. Nursing staff were educated regarding the policy and elopement risk precautions. Element 4 The nurse on duty will assess all residents who are elopement risks for wander guard placement every shift per the MAR. The DON/designee will monitor the MAR for documentation of placement of the wander guard weekly x 4 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly. □	

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F 323	Continued From page 47 At 8:35 a.m. R19 independently ambulated from the breakfast table to her room. At 9:15 a.m. registered nurse (RN)-A checked R19 for a wanderguard bracelet and verified R19 was not wearing one. R19 told RN-A she had never had a bracelet on. At this time the interim director of nursing (DON) stated they had just replaced a wanderguard bracelet on R19 a month ago. On 10/1/14, at 8:06 a.m. nursing assistant (NA)-A stated R19 was not one to wander. NA-A stated she only knew of the one incident when R19 went out into the patio and they were so surprised. NA-A stated there use to be a system where someone would check weekly that the wanderguard was present. NA-A stated she thought the wanderguard was on R19's ankle. At 8:53 a.m. RN-A verified the care plan was not followed regarding the use of the wanderguard. RN-A stated she would like to re-evaluate the use of the wanderguard. RN-A stated R19 did have memory impairment and was known to remove her own wanderguard. RN-A stated they could modify the physician's orders for the wanderguard so the nurses would check for the wanderguard every shift. RN-A stated R19 would go out the front door and out to the patio to check the weather and then would come back in. On 10/2/14, at 9:25 a.m. licensed practical nurse (LPN)-B stated she was not checking the wanderguard for R19 daily. In addition, LPN-B stated in the course of R19 wearing the wanderguard she has cut it off 4-5 times. LPN-B stated she would probably check R19 for the wanderguard when she would go out the door	F 323		

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F 323	Continued From page 48 and the alarm would sound, and added R19 goes outside to "sniff" the air and comes back into the facility without redirection. The Elopement policy dated 10/2/14, indicated residents who elope or have the potential to elope will be identified and have prevention plans designated on their individualized plan of care. Nursing staff would ensure that wanderguards were listed on treatment records and documented daily that the wanderguard was functioning.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		11/12/14

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F 329	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to attempt a dosage reduction for the use of an antidepressant, and failed to monitor efficacy of an antidepressant used for insomnia for continued need, for 2 of 5 residents (R14, R1) reviewed for unnecessary medications. Findings include: R14's Physician Order Report dated 9/3/14, directed Paxil (an antidepressant medication) 10 milligrams (mg) daily for the treatment of depression. The medication was started on 7/3/2013. The clinical record lacked documentation of an attempted dose reduction since start date of 7/13. In addition, the record lacked documentation why a reduction would be contraindicated for R14. R14's quarterly Minimum Data Set (MDS) dated 9/5/14, and the annual MDS dated 7/1014, identified R14 as being alert and oriented with no mood or behavior concerns. The assessment indicated R14 received antidepressant medications daily. The Psychotropic Medication Use Care Area Assessment dated 7/10/14, indicated R14 participated in activities and did not show signs of depression. The care plan dated 7/15/14, identified R14 as receiving antidepressant medication for the treatment of major depression and	F 329	Element 1 Residents R14□s and R1□s medications were reviewed for clinical indications, gradual dose reductions (GDR) were made when the clinical indications reveal the benefit outweighs the risk to decrease and the rationale is documented in the patient chart. Element 2 All residents who take psychotropic medications were assessed for indications for use, appropriateness of gradual dose reduction and documented rationale. Element 3 The policy was reviewed and updated as appropriate. New admission medications will be reviewed for appropriate indications for use. The consulting pharmacist will audit all resident□s medication regimens monthly. SW/RN will monitor all psychotropic medications for gradual dose reductions and documented benefit vs risk rationale at least quarterly. SW, consulting pharmacist and RNs were educated regarding the protocol for gradual dose reduction. Element 4 The consulting pharmacist will audit each resident□s medication regime monthly. SW/RN will review each resident medication regimen at least quarterly.	

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F 329	Continued From page 50 sleeplessness. The care plan directed the staff to encourage the resident to stay up after meals and to participate in activities in the facility. During the survey conducted on 9/29/14, from 4:00 p.m. to 8:00 p.m., on 9/30/14, from 8:00 a.m. to 4:30 p.m., on 10/1/14, from 7:00 a.m. to 3:30 p.m., on 10/2/14, from 8:00 a.m. to 4:30 p.m., and on 10/3/14, from 8:00 a.m. to 12:00 p.m., R14 was observed to participate in activities of choice, wheel himself around the facility, and interacted with other residents, staff and visitors. R14 was not observed to display symptoms of depression. On 10/1/14, at 12:20 p.m. registered nurse (RN)-A stated R14 will occasional sleep when he is depressed. She stated R14 does not show any other symptoms of depression. The Consultant Pharmacist Medication Review completed on 12/10/13, read: "CMS (Center for Medicare/Medicaid services) regulations required two gradual dose reductions or assessment the first year for all psychopharmacological medication to determine the continued need for the order." "Consider a reduction or, if you feel any reduction would put resident in undue psychiatric distress, please list the risk and benefits for this dose." The physician responded, "He is on the lowest dose and tolerated well and his depression is good continue med." The note did not address why reduction would be contraindicated. On 10/1/14, at 1:30 p.m. RN-B stated confirmed the consultant pharmacist brought the concern of antidepressant medication reduction to the attention of the physician in 12/13, but confirmed the medication has not been addressed since that	F 329	The DON/designee will monitor psychotropic medications for GDR or documentation of rationale explaining the benefit vs risk weekly x 4 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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F 329	Continued From page 51	F 329		

time. RN-B stated R14 occasionally naps but does not show any other symptoms of depression.

R1's Resident Admission Record dated 10/2/14, indicated diagnoses that included chronic pain, dysthmic disorder (a chronic type of depression), thoracic spondylosis (degenerative osteoarthritis of the joints between the center of the spinal vertebrae) and insomnia. The current physician's orders printed 10/2/14, directed nortriptyline (an antidepressant) 50 at bedtime.

R1's quarterly MDS dated 7/10/14, indicated R1 was cognitively intact. The MDS also indicated R1 had poor appetite or overeating 2-6 days, felt bad about himself 2-6 days, and received antidepressant medication daily

The Psychotropic Medication Use CAA dated 1/10/14, indicated R1 was alert and oriented, and aware of reasons for medication use. He went willingly to psych visits and was able to self report new symptoms. The CAA also indicated a potential for unwanted side effects from the use of 2 different antidepressant medications.

R1's care plan dated 7/16/14, indicated R1 received nortriptyline for sleep and identified a goal for R1 to receive the lowest dose of medication to alleviate signs and symptoms of insomnia. The care plan directed staff to monitor for signs and symptoms of depression, anxiety and insomnia.

The Consultant Pharmacist's Medication Regimen Review Report dated 7/25/12, identified nortriptyline was started October 2011 and was

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prescribed for chronic pain and neuropathies, along with insomnia and depression.

R1's medical record indicated the most recent sleep monitoring assessment was dated December 2013.

On 09/30/2014, at 2:14 p.m. R1 was observed participating in a bean bag toss activity in the lounge area. R1 was observed to be engaged and participating in the activity. His affect was full and R1 was smiling.

On 10/01/2014, at 1:10 p.m. RN-A stated the facility's side effect monitoring process had just been reorganized and they were planning to start on 10/1/14. RN-A confirmed no sleep monitoring had been done for R1 since December 2013. RN-A stated the facility had lost some staff last year and this had been missed.

On 10/02/2014, at 8:38 a.m. interim director of nursing (DON) confirmed sleep monitoring had not been completed since December 2013, and should have been, as directed by the care plan. DON confirmed she would have expected the pharmacist to have identified the lack of sleep monitoring for the medication.

On 10/02/2014, at 9:18:a.m. R1 stated he slept well. R1 stated he is able to fall asleep and stay asleep throughout the night. R1 also stated if he does wake during the night, he is able to return to sleep without difficulty. R1 further stated he was happy with his medication regimen at this time and had no difficulties.

A policy regarding sleep monitoring was requested but none was provided.

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation,interview and document review, the facility did not post the actual hours worked for each category of licensed and non-licensed staff on a daily basis for 4 of 4 days	F 356	Element # 1 The Staff posting was immediately corrected and placed in a public area.	11/15/14

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F 356	Continued From page 54 of postings reviewed. This had the potential to affect all 26 residents residing in the facility, and any visitors who may have wanted to review the information Findings include: On 9/30/14, at approximately 1:00 p.m. during the initial tour of the facility, the daily nurse staff posting was located in a clear frame at the nurse's desk. The nurse staff posting lacked the actual hours worked by licensed and non-licensed staff. Review of the nurse staff postings for 9/29/14, 10/1/14, and 10/2/14, all lacked the actual hours worked by licensed and non-licensed staff. On 10/2/14, at 9:05 a.m. the director of nursing (DON) verified the nurse staff posting did not include actual hours worked by licensed and non-licensed staff. The DON also stated the current nurse staff posting form only indicated day, p.m., and night shifts, and did not list staff who worked short or split shifts. The Nurse Staffing Requirement policy dated 12/30/12, did not address the posting of actual hours on short shifts or split shifts that staff worked.	F 356	Element # 2 Nurse staffing information is posted daily in an area and at a height readily seen by residents and families. Staffing posts are kept in a book at the nurse□s station for 18 months. Element # 3 A policy has been implemented and educated to licensed staff regarding requirements of nursing staff postings. Element # 4 Postings will be audited by the Director of Nursing/Designee Daily x 7 days, then weekly x 3 weeks and at least monthly x 2 months. Random audits of staffing book and posting will be at least quarterly ongoing. Exceptions will be reported to the Administrator for immediate follow up and reviewed at QA at least quarterly. □	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to	F 428		11/12/14

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F 428	Continued From page 55 the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consultant pharmacist failed to identify and report on the efficacy of pain medications for 2 of 3 residents (R6, R11) who had chronic pain. In addition, the consultant pharmacist failed to identify the need for a dosage reduction and/or continued need for the use of an antidepressant, and failed to identify the lack of monitoring for efficacy of an antidepressant used for insomnia for 2 of 5 residents (R14, R1) reviewed for unnecessary medications. Findings include: R6's quarterly Minimum Data Set (MDS) dated 9/3/14, also indicated R6 had intact cognition, required extensive staff assistance with all activities of daily living and was unable to ambulate. The MDS indicated R6 had diagnosis including cerebral palsy, anxiety, diabetes mellitus and congestive heart failure. The MDS also indicated R6 suffered from frequent pain which prevented her from participating in daily activities. During the assessment period, R6 had reported her pain to be at a 6 on a 0-10 (10 is worst) pain scale. R6's care plan dated 6/4/14, identified an alteration in comfort related to numbness/tingling	F 428	Element 1 The consulting Pharmacist has reviewed the medication irregularities related to PRN pain medications for residents R6, R11, who had chronic pain. Changes have been made as recommended. The consulting pharmacist reviewed R14 and R1□s routing medication irregularities and made recommendations as appropriate. Element 2 The consulting pharmacist has reviewed all resident charts for PRN and routine medication irregularities and made appropriate recommendations. Element 3 The policy and contract regarding consulting pharmacy services and medication review was reviewed with the consulting pharmacist. The consulting pharmacist has access to the EMR for efficiency of pharmacy review. Element 4 The DON/Designee will audit the consulting pharmacist report monthly ongoing. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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F 428	Continued From page 56 in the hands secondary to carpal tunnel syndrome and muscle spasticity secondary to cerebral palsy. The plan directed staff to anticipate her needs and respond in a timely manner. The care plan did not direct staff on how to minimize potential leg pain and it did not include non-pharmacological interventions to minimize R6's pain. The Physician Order Report dated 9/5/14, included Baclofen (muscle relaxer) 10 mg three times a day, Gabapentin (medication used to treat nerve pain) 300 milligrams (mg) three times a day, Tylenol extra strength 500 mg one tablet every four hours as needed (PRN) for pain, and Fentanyl (narcotic pain patch) 25 micrograms (mcg)/ hour to be changed every three days. On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh." On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head. At 9:10 a.m. nursing assistant (NA)-A stated R6 cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication. On 10/2/14, at 9:45 a.m. R6 stated she	F 428		

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F 428	Continued From page 57 experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is receiving her pain medications. Review of the electronic medication administration record (EMAR) revealed the following information about excessive use of as needed Tylenol: 7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol. 7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol. 8/1/14 - 8/31/13, R6 received 81 doses of PRN Tylenol 500 mg. 9/1//14 - 9/30/14, R6 received 98 doses of PRN Tylenol 500 mg. 10/1/14- 10/2/14, R6 had received 6 doses of PRN Tylenol 500 mg. On 10/2/14, at 10:10 a.m. licensed practical nurse (LPN)-B stated R6 reported complaints of pain "all of the time." She stated R6 will request pain medications and will watch the clock waiting for the four hours to pass before she can ask for the next pill. LPN-B stated R6 was uncomfortable, "I wish we could find something to give her relief."	F 428		

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F 428	Continued From page 58 On 10/2/14, at 11:00 a.m. R6's pain was reviewed with the interim director of nursing (DON) and the consultant registered nurse (RN). The interim DON stated she was aware R6 expressed pain daily. The two RNs reviewed R6's clinical record and were unable to find indication in which the staff had completed a comprehensive assessment of R6's pain and were unable to determine if the Fentanyl which had been added in 7/2014, was an effective medication for controlling the pain. On 10/2/14, at 11:20 a.m. the consultant RN confirmed R6 experienced pain daily and had not been comprehensively reassessed by the nurses to determine the extent of the pain. She stated she was aware R6 was utilizing PRN medications for the treatment of pain but was not aware she was utilizing over 70 PRN medications per month. Review of the monthly consultant pharmacist medication regimen reviews indicated the reviews had been completed without any type of concerns identified by the pharmacist. On 10/2/14, at 4:00 p.m. the consultant pharmacist stated she started visiting the facility one month ago. She stated at the time of the consult, she did not have access to the electronic medical records or EMARs. She confirmed she had not reviewed R6's PRN medication usage as she did not have access at the time of the review. She stated if she would have noted that a resident was utilizing over 80 PRN doses of pain medications each month, she would have pointed this out to the attending physician. A policy related to medication reviews was	F 428		

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F 428	Continued From page 59 requested and none was provided. R11's Physician Order Report dated 9/3/14-10/3/14, indicated R11 had diagnoses that included osteoporosis (a disease in which bones become fragile and more likely to fracture), lower leg osteoarthritis (degenerative arthritis affecting the cartilage), chronic pain, and Wegener's granulomatosis (causes inflammation of the blood vessels). R11's significant change MDS dated 8/11/14, indicated R11 had severe cognitive impairment and required extensive assistance of one staff for locomotion on and off the unit, dressing and personal hygiene and limited assistance of one staff for bed mobility, transfer, ambulating in room and corridor and toilet use. The MDS also indicated R11 received scheduled and as needed pain medication and non-medication interventions for pain. The MDS also indicated R11 reported her pain as moderate and frequent but it did not interfere with daily activities or make it difficult to sleep at night. The MDS further indicated R11 received physical therapy (PT) and occupational therapy (OT) services and received active range of motion (ROM) restorative nursing services. R11's care plan dated 7/17/14, identified R11 had alteration in comfort related to pain secondary to history of compression fractures of her back and indicated R11 would verbally state pain was 2-3 on a verbal scale of 0-10 after administration of pain medication. The care plan directed staff to administer medications as ordered for pain and to monitor for effectiveness of pain medications and possible side effects. The Nursing Home Note dated 7/29/14, indicated R11 was seen regarding family concerns related	F 428		

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	245428	A. BUILDING _____ B. WING _____	10/03/2014

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to pain, delirium, hearing and intake issues. The physician's impression included pain issues with vertebral compression fractures and arthritis. The physician's plan was to not change medications until R11's shortness of breath (identified upon physician examination) was evaluated.

R11 was hospitalized from 7/31/14 through 8/4/14, for pneumonia.

The facility completed Pain Data Collection for R11 on 8/5/14 - 8/9/14. The RN assessment summary of the data collection completed on 8/13/14, identified R11 had complained of pain during the assessment period.

The Physician Order Report dated 9/3/14-10/3/14, included orders for Lidoderm adhesive patch (a local anesthetic) 5% (700 milligrams (mg)/patch) apply 1 new patch topically to mid-back daily on 12 hours and off 12 hours for chronic pain, Norco (narcotic pain reliever for moderate to severe pain) 5-325 mg three times a day (scheduled dose), Norco (hydrocodone-acetaminophen) 5-325 mg 1 tab twice a day PRN for pain, and acetaminophen 500 mg 1 tab every 6 hours PRN for pain.

R11's Medication Administration History dated 8/8/14 -10/3/14 revealed:

-Lidoderm adhesive patch 5% was administered early at R11's request 30 of 57 days.

-Norco 5-325 mg three times a day (scheduled dose) was given early for the morning dose on 8/25, 9/12, 9/22, 9/25, 9/26, 9/29, 9/30, 10/1, 10/2, and 10/3 and for the afternoon dose on 9/9

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F 428	Continued From page 61 (11 doses). R11's PRN Medications Administration History 8/8/14-10/3/14 revealed: -Norco 5-325 mg 1 tab twice a day PRN, 32 doses were given on 29 of 57 days for complaints of pain in knees or legs. -acetaminophen 500 mg 1 tab every 6 hours as needed was given once on 8/8, 8/30, and 9/3 and given three times on 10/2 for complaints of pain in knees or legs. On 10/2/14, at 9:04 a.m. R11 was observed seated in her room seated in a recliner. R11 stated she had been having a lot of problems with her right knee and raised her pant leg above her knee and began to rub it. The knee was observed to be swollen. R11 stated she was given pain pills for the knee pain and that they lasted a little while "but they don't last forever." She stated that on 10/1/14, she was given cold packs, as well, and that helped for a little bit. R11 stated the pain keeps her up at night at times and that the previous night she was "up a lot" until she finally got a pain pill. R11 stated the pain medication lasted for about 4 hours before her knee began hurting again. R11 also stated she asks for a pain pill a couple of times a day and identified her pain at that time at an 8 out of 10. On 10/2/14, at 10:43 a.m. R11 was observed seated in her room in a recliner with a wheeled walker in front of her chair. R11 stated the pain limited her activities during the day and prevented her from joining in. She stated, "I just can't do it." R11 stated her knee currently still ached and was a 7 out of 10 on a 1 to 10 pain scale. R11 stated her knee hurt all the time but it was alright if she sat "absolutely still." R11 further indicated	F 428		

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F 428	Continued From page 62 walking made her knee feel worse. On 10/02/2014, at 2:39 p.m. LPN-B stated R11 received scheduled pain medication three times a day and could also have PRN pain medication for her knee pain. She stated if R11 asked for extra pain medication, it was usually needed on the night shift but was occasionally given during the day. LPN-B stated PRN Norco was usually given. Review of the monthly consultant pharmacist medication regimen reviews indicated the reviews had been completed without any concerns regarding pain management identified by the pharmacist. On 10/2/14, at 3:45 p.m. the consultant pharmacist stated she started visiting the facility one month ago. She stated at the time of the consult, she did not have access to the electronic medical records or EMARs. She confirmed she had not reviewed R11's pain medication usage as she did not have access at the time of the review. A policy related to medication reviews was requested and none was provided. R14's Physician Order Report dated 9/3/14, directed Paxil (an antidepressant medication) 10 mg daily for the treatment of depression. The medication was started on 7/3/2013. The clinical record lacked documentation of an attempted dose reduction since start date of 7/13. In addition, the record lacked documentation why a reduction would be contraindicated for R14. R14's quarterly MDS dated 9/5/14, and the	F 428		

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annual MDS dated 7/1014, identified R14 as being alert and oriented with no mood or behavior concerns. The assessment indicated R14 received antidepressant medications daily.

The Psychotropic Medication Use Care Area Assessment dated 7/10/14, indicated R14 participated in activities and did not show signs of depression.

The care plan dated 7/15/14, identified R14 as receiving antidepressant medication for the treatment of major depression and sleeplessness. The care plan directed the staff to encourage the resident to stay up after meals and to participate in activities in the facility.

On 10/1/14, at 12:20 p.m. RN-A stated R14 will occasional sleep when he is depressed. She stated R14 does not show any other symptoms of depression.

The Consultant Pharmacist Medication Review completed on 12/10/13, read: "CMS (Center for Medicare/Medicaid services) regulations required two gradual dose reductions or assessment the first year for all psychopharmacological medication to determine the continued need for the order." "Consider a reduction or, if you feel any reduction would put resident in undue psychiatric distress, please list the risk and benefits for this dose." The physician responded, "He is on the lowest dose and tolerated well and his depression is good continue med." The note did not address why reduction would be contraindicated.

On 10/1/14, at 1:30 p.m. RN-B stated confirmed the consultant pharmacist brought the concern of

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antidepressant medication reduction to the attention of the physician in 12/13, but confirmed the medication has not been addressed since that time. RN-B stated R14 occasionally naps but does not show any other symptoms of depression.

On 10/2/14, at 4:00 p.m. the consultant pharmacist stated she started visiting the facility one month ago. She stated at the time of the consult, she did not have access to the electronic medical records or EMARs. She stated she had noticed R14 was receiving Paxil but did not feel she should make any type of recommendations until she could review the clinical record and get to know the resident a bit more. The pharmacist confirmed residents receiving antidepressants were to receive two attempted dose reductions during the first year.

R1's Resident Admission Record dated 10/2/14, indicated diagnoses that included chronic pain, dysthmic disorder (a chronic type of depression), thoracic spondylosis (degenerative osteoarthritis of the joints between the center of the spinal vertebrae) and insomnia. The current physician's orders printed 10/2/14, directed nortriptyline (an antidepressant) 50 at bedtime.

R1's quarterly MDS dated 7/10/14, indicated R1 was cognitively intact. The MDS also indicated R1 had poor appetite or overeating 2-6 days, felt bad about himself 2-6 days, and received antidepressant medication daily

R1's care plan dated 7/16/14, indicated R1 received nortriptyline for sleep and identified a goal for R1 to receive the lowest dose of

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medication to alleviate signs and symptoms of insomnia. The care plan directed staff to monitor for signs and symptoms of depression, anxiety and insomnia.

The Consultant Pharmacist's Medication Regimen Review Report dated 7/25/12, identified nortriptyline was started October 2011 and was prescribed for chronic pain and neuropathies, along with insomnia and depression.

Review of the monthly consultant pharmacist medication reviews indicated the reviews had been completed without any concerns regarding nortriptyline use identified by the pharmacist.

R1's medical record indicated the most recent sleep monitoring assessment was dated December 2013.

On 10/01/2014, at 1:10 p.m. RN-A stated the facility's side effect monitoring process had just been reorganized and they were planning to start on 10/1/14. RN-A confirmed no sleep monitoring had been done for R1 since December 2013. RN-A stated the facility had lost some staff last year and this had been missed.

On 10/02/2014, at 8:38 a.m. interim DON confirmed sleep monitoring had not been completed since December 2013, and should have been, as directed by the care plan. DON confirmed she would have expected the pharmacist to have identified the lack of sleep monitoring for the medication.

On 10/2/14, at 3:49 p.m. the consultant pharmacist stated she only made one visit to the

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F 428	Continued From page 66 facility and had not had a chance to get to know the residents and their history. She stated the physician may have changed the indication for R1's nortriptyline use to address his neurogenic pain rather than for sleep and then may have suspended sleep monitoring. A policy regarding sleep monitoring was requested but none was provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must 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	F 441		11/12/14

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F 441	Continued From page 67 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 use proper infection control practices for 7 of 7 residents (R3, R2, R10, R32, R31, R6, R4) who used a blood glucose monitoring machine to check their blood sugar levels. In addition, the facility's infection control (IC) program lacked a surveillance program and investigation of infections for tracking trends and analysis of data to determine interventions to prevent the spread of infections. The lack of surveillance had the potential to affect 26 of the 26 residents who resided in the facility. Findings include: On 9/29/14, at 5:28 p.m. licensed practical nurse (LPN)-C applied gloves and obtained blood from R4's finger to check her blood sugar level with the blood glucose monitoring (BGM) machine. LPN-C stated they used the one facility BGM machine for all the residents who required blood sugar checks. LPN-C was observed to clean the BGM machine with a sani wipe towelette. The package information indicated the towelette contained the active ingredient 70% alcohol antiseptic.	F 441	Element 1 The facility reviewed the infection control surveillance program and found it had not completed after May 2014. Surveillance, including investigation, trending and analysis of data to determine interventions to prevent the spread of infections was completed for June, July, and August, 2014. The product used for cleansing the glucometer was immediately changed to an EPA approved germicidal cleanser. Element 2 The facility completed surveillance for September, 2014 and nursing is identifying infections and antibiotic use as they occur. An EPA approved germicidal cleanser is used on all glucometers in the facility. Element 3 The policy regarding IC surveillance was reviewed and the policy regarding cleansing of glucometers was updated as appropriate. Licensed nursing staff was educated regarding IC surveillance and	

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F 441	Continued From page 68 R3 had a physician's order dated 7/22/13, for blood sugar checks twice daily four days a week. R2 had a physician's order dated 9/19/14, for blood sugar checks daily. R10 had a physician's order dated 6/10/13, for blood sugar checks three times a day. R32 had a physician's order dated 9/25/14, for blood sugar checks four times a day. R31 had a physician's order dated 8/21/14, for blood sugar checks four times a day. R6 had a physician's order dated 12/6/13, for blood sugar checks daily. R4 had a physician's order dated 12/26/13, for blood sugar checks four times a day. On 9/29/14, at 5:41 p.m. LPN-C stated they were told they could not use the sani wipe clothes as they would damage the BGM machine. LPN-C stated they were instructed to only use the sani wipe towelettes and a sign indicating this was posted at the nurse's station. On 10/2/14, at 8:49 a.m. the interim director of nursing (DON) stated an employee from the laboratory stated not to use the sani wipe clothes to clean the BGM machine as it would damage it. At this time the consulting registered nurse (RN) stated she would check the manufacturer's instructions for the towelettes to determine the active ingredients. At 10:05 a.m. the consulting RN stated she was surprised that one individual from the laboratory would have made the decision to change the disinfecting product for the BGM machine. The consulting RN stated she had checked the manufacturer's instructions for the towelettes and reported they did not kill blood borne pathogens.	F 441	cleansing of glucometers. An infection control nurse has been identified and trained regarding surveillance and glucometer cleansing. Element 4 The Administrator/Designee will audit IC surveillance monthly x 3 months and then quarterly ongoing. Variances will be reviewed at QAPI at least quarterly. □	

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F 441	Continued From page 69 The consulting RN stated they were changing their disinfecting product that day for the BGM machine back to the sani wipe clothes that do kill blood borne pathogens. The consulting RN stated the sani wipe towelettes only contained alcohol and inactive ingredients. At 10:45 a.m. the consulting RN stated she checked with the laboratory personnel and stated it had been about a month since the disinfecting product was changed. SURVEILLANCE On 10/2/14, at 8:51 a.m. the consulting RN stated May 2014, was the last time surveillance of resident infections was done. The interim DON stated the RN who was doing the IC resident tracking had resigned and therefore the surveillance for residents had not been completed. The Surveillance of Health Care associated Infections policy revised 4/12, indicated the infection control officer would perform ongoing total or target house surveillance activities under the direction of the Infection Prevention and Control Committee. A policy was requested regarding the disinfecting of the accu check machine and none was provided.	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	F 465		11/12/14

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F 465	Continued From page 70 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain resident rooms and common areas clean and in good repair for 8 of 8 resident rooms (#121, 126, 132, 101, 102, 103, 104 and 105) and throughout the dining area and facility corridors. Findings include: On 10/1/14, at 11:45 a.m. a tour of the facility was completed with the maintenance director (MD). -The south wall of the dining room had black scuff marks approximately 4 feet by a 1 foot area. -The long wall of the dining room was 22 feet long and had a chair railing. Approximately 4 inches down from the chair railing were numerous black scuff areas on the wall. -The East wall of the dining room was 5 feet long with a chair railing. Approximately 4 inches down from the chair railing were numerous black scuff areas on the wall. -The West wall of the dining room was 7 feet by 33 inches with various black scuff marks. -The back North dining room wall was 3 feet by 1 foot, and the East wall was 14 inches by 10 inches. Both walls have numerous black scuff marks. The MD stated the dining room walls were made of plastic. The MD stated the black scuff marks could be removed by the housekeeping staff with a magic eraser. The MD stated they had also used a special coating paint for the plastic in the past.	F 465	Element 1 Resident rooms (121, 126, 132, 101, 102, 103, 104, 105), bathrooms, and common areas as identified during the survey have been maintained, cleansed and painted. Element 2 An audit of resident rooms, bathrooms, and common areas was performed for identification of other areas in need of maintenance, cleansing or painting. Element 3 A mechanism is in place for maintenance notification of resident rooms, bathrooms, and common areas in need of maintenance, cleansing or painting. All staff has been educated on identify, reporting, and obligation to provide clean and sanitary conditions. There is schedule for maintenance to observe resident rooms, bathrooms, and common areas in need of maintenance, cleansing, paint. Element 4 The Administrator/Designee will audit maintenance observation schedule and repair work weekly x 4 weeks, then monthly x 2 months and quarterly ongoing. Variances will be reviewed at QAPI at least quarterly. □	

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-The East wall corridor outside the porch area, was 8 feet by 10 inches with numerous black scuff marks.
-The West wall outside the porch area, was 12 feet by 15 inches with numerous black scuff marks.
-The West corridor outside the living room was 14 feet by 12 inches with numerous black scuff marks.
-The East wall outside the living room was 8 feet by 12 inches with numerous black scuff marks.

-The walls by the resident/staff restroom were 30 inches by 3 feet, and 6 feet by 40 inches with black scuff marks.
-The West wall of the sun room was 8 feet by 30 inches. The South wall was 11 feet by 2 feet, and the East wall was 7 feet by 12 inches long with numerous black scuff marks.

-In room 121 there were several gouges in the wooden door to the room.
-In room 126 there was sheetrock and paint missing from the walls.
-In room 132 there were several gouges in the wooden door to the room.
-In room 101 the walls had black scuff marks. In addition, there was duct tape on the door face over the chipped wood. There were several gouges in the wooden door to the room.

-In room 102 there was paint missing above the bed. The South wall was 80 inches by 3 feet with numerous black scuff marks
-In room 103 there were several gouges in the wooden door to the room.
-In room 104 the West wall was 3 feet by 12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245428	A. BUILDING _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CENTER	**115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636**

(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 465	Continued From page 72 inches and the South wall was 4 feet by 1 foot with numerous black scuff marks. -In room 105 the bathroom register had an area 45 inches by 7 inches scraped down to the bare metal. The East wall was 41 inches by 13 inches with black scuff marks. -The entire East hallway 100 feet long had numerous black scuff marks on the lower level of the plastic walls. -The North hallway 74 feet long had numerous black scuff marks on the lower level of the plastic walls. The MD stated the black scuff marks were from wheelchairs and mechanical lifts hitting the walls. The MD stated the housekeeping staff did the wall cleaning and the maintenance staff would do the repairs and the painting. On 10/1/14, at 12:42 p.m. maintenance staff (MS)-A stated an annual building inspection was scheduled for September 2014, and had not been completed. On 10/2/14, at 8:40 a.m. the nutrition services manager (NSM) stated she took over the role of monitoring the housekeepers in April 2014. The NSM stated there had been turnover with the housekeepers, and they were short in the housekeeping department and there were two positions open. At 9:30 a.m. the NSM stated they do extra cleaning during an eight week period in the spring. The NSM stated there was no documentation the cleaning was done.	F 465		

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F 465	Continued From page 73 The routine housekeeping policy dated 1/91, indicated the facility would be maintained in a clean, sanitary, and orderly condition. During the extra cleaning which covered an eight week period all the walls in hallways, resident rooms and bathrooms would be washed.	F 465		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide annual evaluations for 4 of 6 nursing assistants, (NA-H NA-E, NA-D, NA-G) reviewed that have worked in the facility for greater than 12 months. Findings include: NA-H was hired on 8/2/07. NA-H's most current Employee Performance Appraisal was dated 2012 and had not been reviewed with NA-H.	F 497	Element 1 Nurse assistant evaluations for NA-A, NA-E, NA-D, NA-G, NA-H, and NA-B have been completed. Element 2 An audit of recent of nurse assistant evaluations was performed and evaluations have been completed on all nurse assistants for 2014.	11/12/14

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F 497	Continued From page 74 NA-H's personnel file lacked a current annual performance review. NA-E was hired on 4/15/04. NA-E's last Employee Performance Appraisal was dated 2012. The Performance Appraisal had not been reviewed with NA-E. Her personnel file lacked a current annual performance review. NA-D was hired on 11/10/03. NA-D's last Employee Performance Appraisal was dated 2012. The Performance Appraisal had not been reviewed with NA-D. Her personnel file lacked a current annual performance review. NA-G was hired on 5/14/90. NA-G's last Employee Performance Appraisal was dated 2012. The Performance Appraisal had not been reviewed with NA-G. Her personnel file lacked a current annual performance review. On 10/3/14, at 11:50 a.m. the consultant registered nurse (RN) stated the facility was currently working on completing the employee annual performance evaluations. She stated she was aware the evaluations had not been completed timely and the facility had set a goal to have them completed by October 1, 2014. She confirmed the personnel files lacked annual performance evaluations. The Employee Performance Evaluations policy dated 1/2006, indicated annual evaluations were to be completed with each employee.	F 497	Element 3 Policy has been reviewed and education has been provided to the nurse assistants supervisors (RNs) regarding the requirement for annual evaluations of nurse assistants. Element 4 The DON/Designee will audit completion of nurse assistant evaluations annually by November. Variances will be reviewed at QAPI at least quarterly.	

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	245428	A. BUILDING **01 - NURSING HOME** B. WING _____	**09/30/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE 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 Homestead Rehabilitation and 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	EPOC	

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

Electronically Signed | 10/30/2014

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 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 Homestead Rehabilitation and Living Center is a 1-story building without a basement that is attached to a hospital. The building was constructed in 2 major stages. The original building was constructed in 1973, was determined to be of Type II(111) construction. In 1990 an addition to the north of the building was constructed and was determined to be of a Type II(111) construction. The hospital is separated from the nursing home building with two hour fire barriers and was not inspected at this time. The building is divided into 2 smoke zones. The building is completely sprinkler protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response heads, except as noted in K56. The facility has a fire alarm system with smoke detection throughout the corridor system, in spaces open to the corridors and in all sleeping rooms that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code"	K 000		

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K 000	Continued From page 2 (1999 edition). Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition) The facility has a capacity of 32 beds and had a census of 26 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings the facility was surveyed as a single building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 70(99) and NFPA 72(99) edition. 9.6.1.4.This deficient practice could affect all building occupants.	K 052	K052 Fire alarm system test was completed on July 2 2014. All fire alarm system tests will be inserted into a document binder upon receipt. Fire alarm system along	11/12/14

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K 052	Continued From page 3 Findings include: At the conclusion of the inspection tour at approximately 9:00AM, on 9-30-14, review of available documentation indicated that the last annually required inspection, testing, and maintenance of the fire alarm system, in accordance with NFPA 72, was conducted on 7-13. This deficient practice was not verified by the facility Maintained Director (MC) at the time of this inspection.	K 052	with all devices will be inspected and certified annually by an outside fire alarm testing company who will remain under agreement to meet NFPA-72 requirements.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review,observation and interview, the facility has failed to properly maintain the sprinkler system. This deficient practice could affect all occupants including residents, staff and visitors. Findings include: At the conclusion of the tour on 9-30-14 at approximately 9:00AM, it was discovered, during review of available documentation, and interview with the Director of Facility Maintenance , that the facility had not had the licensed vendor conduct	K 062	Sprinkler system testing had been scheduled and was completed on 10-2-2014. Fire suppression system will be tested quarterly and certified annually by an outside sprinkler testing company who will remain under agreement to meet NFPA-25 requirements.	11/12/14

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K 062	Continued From page 4 the required annual inspection, testing and maintance done on the complete automatic fire sprinkler system since 7-16-13, as required by NFPA 25. This deficient practice was confirmed by the Director of Maintenance (MC) at the time of exit.	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on review of available documentation the kitchen hood extinguishment system is not properly being maintained in accordance with MSFC(07) section 904.5.1 & NFPA 96. This deficient practice could effect all building occupants in the event of a fire under the hood. Findings include: At the conclusion of the facility tour on 9-30-14 at approximately 9:00AM, based on a review of available documentation, the last inspection. testing and maintenance of the kitchen hood extinguishment system was completed more then 6 months ago. This procedure is required every 6 months. This deficient practice was not confirmed by the Director of Maintenance (MC) at the time of exit.	K 069	Cooking Equipment Ansul system had been scheduled and was tested on 10-2-2014. The kitchen ansul fire suppression system will be tested and certified bi-annually by an outside sprinkler testing company who will remain under agreement to meet NFPA-25 requirements.	11/12/14

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
October 22, 2014

Mr. Michael Hedrix, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5428024

Dear Mr. Hedrix:

The above facility was surveyed on September 29, 2014 through October 3, 2014 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.

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00296	A. BUILDING: _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CEN	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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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 9/29/14, 9/30/14, 10/1/14, 10/2/14, and 10/3/14, surveyors of this Department's staff, visited the above provider and the following correction orders are 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	2 000		

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program,705 5th street Suite A, Bemidji, MN 56601.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview the facility failed to ensure	2 302	The facility provided information to	11/12/14

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2 302	Continued From page 2 that consumers received information on a description of the Alzheimer's training program provided at the facility for employees. This had the potential to affect all 26 residents and any consumers who wanted to review the information. Findings include: On 10/2/14, at 1:37 p.m. the consulting registered nurse (RN) stated she knew the family council and others had been made aware of the dementia training at the facility, however, there would not be documentation to show that the consumers had received the information.	2 302	consumers regarding the Alzheimer's training program as Required by state and federal regulators via local news paper.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to address medications and appropriate interventions to meet the needs for 1 of 5 residents (R31) whose medication regimen was reviewed; failed to develop a care plan related to pain interventions for 3 of 3 residents (R6, R25, R11) who had expressed pain; and failed to	2 560	Element 1 Residents (R6, R25, and R11) have had a comprehensive assessment of pain. The assessment tool has been analyzed and updated and comprehensive care plans have been developed and implemented. Resident (R9) has been interviewed and a care plan is in place to encourage the	11/12/14

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2 560	Continued From page 3 develop a care plan for hair care for 1 of 4 residents (R9) who routinely refused assistance with hair care. Findings include: R31's care plan dated 10/1/14, did not address the use of Celexa (an antidepressant) 10 milligrams (mg) daily for depressed mood and adjustment disorder, and did not address the use of Ferrous Sulfate (an iron supplement) 324 mg twice daily to treat a lack of red blood cells. R31's physician's orders dated 9/10/14, directed Ferrous Sulfate 324 mg two times a day. R31's physician's orders dated 9/16/14, directed Celexa 10 mg daily. At 8:44 a.m. registered nurse (RN)-A verified the Ferrous Sulfate and Celexa should be addressed on the care plan. R6 experienced continued left leg pain and the care plan did not address interventions to minimize/reduce pain. R6's care plan dated 6/4/14, identified an alteration in comfort related to carpal tunnel syndrome and muscle spasticity secondary to cerebral palsy. The care plan directed the staff to anticipate her needs and respond in a timely manner. The care plan did not direct the staff how to minimize potential pain nor did it include non-pharmacological interventions to minimize R6's pain. On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh." No staff members	2 560	highest level of hair care acceptable to the resident. Resident (R31) has an updated care plan to address the medication regimen. The same resident (R31) has been evaluated for wheel chair positioning and the care plan has been updated. Element 2 All resident care plans have been reviewed and updated to reflect appropriate pain management, hair care choices, medication regimens, and wheel chair positioning. Element 3 The facility□s care planning policy has been updated as necessary and education has been provided to licensed nursing staff. Element 4 20% of resident care plans will be audited weekly by the DON or designee for 4 weeks, then monthly for 2 months, and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly. □	

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2 560	Continued From page 4 were observed in the dining room as R6 cried holding her head. A few moments later nursing assistant (NA)-A walked up to R6 and escorted her to her room. On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head. On 10/2/14, at 9:10 a.m. NA-A stated R6 cried out in pain every day. NA-A stated R6 will complain while sitting in her wheelchair. NA-A reported R6 receives pain medications for pain management but she often has to wait until it is time for the next medication. NA-A stated R6 frequently watches the clock in her room waiting for the next pain medication. On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg wakes her at night and she often has to watch the clock to wait for her next dose of pain medications. R6 described the pain as a "toothache that never goes away." She stated the pain prevented her from participating in many of the activities in the facility because sometimes it was better in the chair... and other times it was better in bed. R6 described the pain as being at an 8 or 9 on a 0-10 (10 worst) pain scale daily. R6 stated she has to watch the clock to make sure she is receiving her pain medications. On 10/2/14, at 10:00 a.m. NA-D stated R6 expressed pain in her left leg every day. She	2 560		

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2 560	Continued From page 5 stated she attempts to reposition R6 in bed or rub her leg, but it usually does not give R6 pain extended relief. She stated R6 may have a few moments of pain relief, but it did not last long. On 10/2/14, at 10:10 a.m. licensed practical nurse (LPN)-B stated R6 reported complaints of pain "all of the time." She stated R6 will request pain medications and will watch the clock waiting for the four hours to pass before she can ask for the next pill. LPN-B stated R6 was uncomfortable, "I wish we could find something to giver her relief." On 10/2/14, at 11:20 a.m. the consultant RN confirmed R6 experienced daily pain daily and the care plan did not address pharmacological and non-pharmacological interventions to reduce/minimize R6's pain. R25's care plan dated 8/5/14, did not address the need to elevate legs due to edema, the use of Demedex (a diuretic) 10 mg daily for weight gain/edema, or the use of as needed acetaminophen (Tylenol) 650 mg for break through pain. Nor did it address the use of non-pharmacological interventions to relieve pain other than ambulation. R25's care plan last revised 8/5/14, indicated pain would be rated on a scale of 1-10 by resident and as needed (PRN) medications may be given. Interventions indicated R25 was to participate in ambulation and exercises to decrease pain. There were no other non-pharmacological interventions included on the care plan. The 10/2/2014, physician's order report indicated R25's current medications included: methotrexate sodium (used to treat severe rheumatoid arthritis) 25/ml (milliliters) injection every 7 days, Fentanyl	2 560		

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2 560	Continued From page 6 patch every 72 hours 50 mcg/hr (hour), change every 3 days, Demadex 10 mg every day, Percocet 5/325 mg 1 tablet every 4 hours PRN, acetaminophen 325 mg two tablets PRN every 4 hours for minor or breakthrough pain and give between scheduled Percocet doses if needed. Do not exceed 3000 mg [acetaminophen] total in 24 hours. During interview on 9/30/2014, at 7:42 p.m. R25 stated she had discomfort in both of her legs. Review of the EMAR indicated on 10/1/14, at 1:57 a.m. PRN Percocet 5/325 mg. one tablet was given due to left leg, and right and left heel pain. During interview on 10/1/2014, at 7:05 a.m. R25 stated as she lay in bed moaning "oh my leg hurts." Surveyor asked her if she had told anybody and she stated, "No, they know and all staff are busy." At 7:15 a.m. R25 stated both of her legs hurt, "they are hard as a rock, just feel them." At that time R25 removed her covers and showed the surveyor her legs that appeared shiny and firm to the touch. At 7:45 a.m. nursing assistant (NA)-D was observed assisting R25 wash up for the day. R25 stated her groin/crotch area was swelled up and so tight. At 7:50 a.m. R25 stated as she transferred from toilet to w/c, "oh my knees hurt." NA-D stated, "Oh that darn arthritis." At 8:15 a.m. R25 stated her legs hurt and added, "They don't stop hurting." NA-D wheeled her to the dining room. On 10/1/14, at 8:27 a.m. LPN-A gave R25 PRN Percocet 5/325 mg. for pain. R25 rated her pain at an 8.	2 560		

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2 560	Continued From page 7 On 10/1/14, at 10:00 a.m. RN-B verified the care plan did not address the items and should be on the care plan R11 experienced continued right knee pain and the care plan did not address interventions to minimize/reduce pain other than to administer medications. R11's care plan dated 7/17/14, identified R11 had alteration in comfort related to pain secondary to history of compression fractures of her back and indicated R11 would verbally state pain was 2-3 on a verbal scale of 0-10 after administration of pain medication. The care plan directed staff to administer medications as ordered for pain and to monitor for effectiveness of pain medications and possible side effects. The care plan did not identify or address R11's right knee/joint pain, nor did it identify non-pharmacological interventions for pain. On 10/2/14, at 9:04 a.m. R11 was observed in her room, seated in a recliner. R11 stated she had been having a lot of problems with her right knee and raised her pant leg above her knee and began to rub it. The knee was observed to be swollen. R11 stated she was given pain pills for the knee pain and stated they lasted a little while "but they don't last forever." She stated that on 10/1/14, she was given cold packs and that helped for a little bit. R11 stated the pain kept her up at night at times and the previous night she was "up a lot" until she finally got a pain pill. R11 stated the pain medication lasted for about 4 hours before her knee began hurting again. R11 also stated she asked for a pain pill a couple of times a day and identified her pain right now at an 8 out of 10 on a 1 to 10 scale.	2 560		

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2 560	Continued From page 8 On 10/02/2014, at 10:02 a.m. R11 was observed ambulating back toward her room after her bath. R11 was observed to be limping on her right leg. R11 stated her knee felt much better after her whirlpool bath. On 10/02/2014, at 10:48 a.m. NA-B stated R11 had pain daily and may have had more pain lately since recently bumping her right knee. On 10/02/2014, at 10:55 a.m. NA-D stated R11 had pain every day and received pain medication for the pain. NA-D indicated she was not aware of any non-pharmacological interventions for the relief of R11's pain nor was she aware of factors that aggravated R11's pain. NA-D further indicated R11's pain was mostly in her knees. On 10/02/2014, at 2:39 p.m. LPN-B stated R11 received scheduled pain medication three times a day and could also have PRN pain medication for her knee pain. LPN-B indicated R11 had used warm packs on her legs previously, but stated they had only done so very occasionally, and it had been about a month since the warm packs had been used. LPN-B indicated that the warm packs had been effective, and R11 had liked the warm packs when used in the past. LPN-B indicated that if R11 currently indicated she was in pain and had just had a pain pill, they instructed her to elevate her legs and take it easy until the medication worked. On 10/02/2014, at 3:12 p.m. interim DON and consultant RN confirmed the care plan did not identify interventions to minimize R11's right knee pain.	2 560		

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2 560	Continued From page 9 R9's care plan did not address her routine refusal of assistance with hair care. R9's Resident Admission Record dated 10/2/14, indicated R9 had diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, major depressive disorder, hemiplegia (paralysis on one vertical half of the body), and polyneuropathy in diabetes (nerve damage causing numbness, loss of sensation and sometimes pain in feet, legs and hands caused by diabetes) R9's quarterly Minimum Data Set (MDS) dated 8/30/14, indicated R9 had severe cognitive impairment and required extensive assistance of two staff for personal hygiene. R9's activities of daily living (ADL)/Functional Care Area Assessment (CAA) dated 12/2/13, indicated R9 had hemiplegia and overall weakness and spent her days in bed per her preference. The CAA indicated R9 would occasionally get up for bingo. The CAA also identified R9 required maximum to total assist with dressing, grooming and bathing and R9 refused to get out of bed except occasionally for bingo or a bath. R9's care plan dated 9/2/14, identified R9 had a self care deficit related to grooming and bathing related to history of stroke with left sided weakness and paralysis. The care plan also indicated R9 stayed in bed and wore house dresses daily. The care plan directed staff R9 required assist of one with grooming, and comb hair daily. The care plan further directed staff R9 required assist of one with partial bathing twice per day with hair wash in bed weekly, or if resident would get up hair wash in beauty shop.	2 560		

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2 560	Continued From page 10 The care plan did not identify R9's routine refusal of hair care or identify interventions to minimize/reduce refusal of care. On 09/29/2014, at 3:53 p.m. R9 was observed to be lying in bed. Her hair was observed to be unclean. On 9/30/14, at 1:18 p.m. R9 observed resting in bed. Her hair was noted to be unclean. On 10/01/2014, at 7:49 a.m. R9 was observed lying in bed. Her hair was observed to be unclean. On 10/1/14, at 7:55 a.m. R9 stated she receives a bed bath. She stated she received a bed bath on 9/30/14, but did not know if her hair had been washed. On 10/01/2014, at 9:42 a.m. NA-B and NA-D stated R9 usually refused to have her hair washed. NA-B indicated R9 does not like the mess it caused to wash her hair in bed. NA-D indicated R9 had refused alternatives such as cap shampoo or dry shampoo. NA-B stated R9 would sometimes allow her hair to be washed in the beauty shop when she got up. NA-B and NA-D stated R9 would frequently go longer than 2 weeks without washing her hair. Both indicated R9 liked to have her hair colored and would allow her hair to be washed at that time. On 10/01/2014, at 11:55 a.m. NA-B indicated she reapproached R9 and she refused a hair wash. On 10/01/2014, at 1:47 p.m. RN-A stated R9 was supposed to have her hair washed weekly. RN-A confirmed R9's hair was "grimy" on 9/30/14. RN-A stated R9 was able to express her own	2 560		

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2 560	Continued From page 11 preferences and needs, and would often refuse such care. On 10/02/2014 at 8:43 a.m. the interim DON confirmed the refusal of hair care and grooming was not on R9's care plan, and verified it should have been. On 10/02/2014, at 8:48 a.m. R9 stated she didn't like to have her hair washed in bed, she didn't like the mess it created. R9 stated she liked to have her hair washed at the beauty shop,and would like to have her hair colored. R9 further stated she had felt weak lately and hadn't wanted to make the attempt to get up and get it done. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service licensed staff to develop a care plan to include appropriate interventions for all identified care needs. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		11/12/14

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2 565	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 1 of 1 resident (R19) who required a wanderguard, and 1 of 1 resident (R4) reviewed for timely positioning and incontinence care. Findings include: R19's care plan dated 6/30/14, indicated R19 wore a wanderguard to prevent injury from unknowingly leaving the building. On 9/30/14, at 9:05 a.m. the surveyor was unable to find the wanderguard bracelet on R19's ankles. On 10/1/14, at 7:55 a.m. R19 was observed not to have the wanderguard bracelet on her ankles. At 9:15 a.m. registered nurse (RN)-A checked R19 for a wanderguard bracelet and verified she not wearing one. On 10/1/14, at 8:53 a.m. RN-A verified the care plan was not followed regarding the use of the wanderguard. R4's care plan dated 9/11/2014, indicated R4 was to be turned and repositioned every 1 1/2 hours when up in her wheel chair, and offered toileting every two hours. On 10/1/14, at 7:05 a.m. R4 was observed sitting at the dining room table. R4 was wheeled to the bathroom, and transferred with a mechanical lift onto the toilet at 9:25 a.m.	2 565	Element 1 A wander guard was placed on resident R19 who is identified as an elopement risk. Nurses are checking placement of the wander guard every shift per the MAR. Element 2 A baseline audit of all residents who are elopement risks were assessed for placement of wander guards. All residents wander guard placement is being checked by nursing ever shift per the MAR. Element 3 The policy was reviewed and updated as appropriate. Nursing staff were educated regarding the policy and elopement risk precautions. Element 4 The nurse on duty will assess all residents who are elopement risks for wander guard placement every shift per the MAR. The DON/designee will monitor the MAR for documentation of placement of the wander guard weekly x 4 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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2 565	Continued From page 13 On 10/1/2014, at 9:30 a.m. nursing assistant (NA)-H stated R4 was placed in her wheel chair at 6:30 a.m. and had not been repositioned or toileted since that time (2 hours and 55 minutes). NA-H stated R4 was to be repositioned and toileted every 2 hours. On 10/1/14, at 12:20 p.m. RN-A verified the care plan was not followed regarding repositioning and toileting. The undated care planning policy indicated an interdisciplinary team would develop and implement a comprehensive care plan that was individualized and designed to meet the needs of the resident. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to ensure all care plans inteventions are followed according to individualized needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		11/12/14

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2 830	Continued From page 14 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive assessment of pain, and failed to implement interventions in an attempt to manage chronic pain for 3 of 3 residents (R25, R6, R11) reviewed who experienced pain. Failure to alleviate pain resulted in actual harm for R25, R6 and R11. In addition, the facility failed to provide wheelchair positioning for 1 of 1 resident (R31) who had improper wheelchair positioning. Findings include: R25 was experiencing moderate to severe pain on a regular basis despite receiving narcotic pain medications and without adequate assessment of the pain. In addition, non-pharmacological interventions were not implemented to help alleviate pain. R25's significant change MDS dated 7/10/14, indicated R25 was cognitively impaired, understood others, had the ability to make self-understood and was able to express ideas and wants both verbally and non-verbally. The MDS indicated R25 required supervision with walking and dressing and was independent with	2 830	Element 1 Residents R25, R6 and R11 were immediately effectively treated for pain and monitored around the clock. Comprehensive pain assessments were performed and analyzed. An interdisciplinary team form and new regimen have been created to address both pharmacologic and non-pharmacologic interventions to meet the individual resident□s pain goal. R31 was evaluated and provided a chair that meets positioning needs. Element 2 A comprehensive pain assessment was performed on all residents in the facility and care plans updated and implemented to meet all resident pain goals including pharmacologic and non-pharmacologic pain goals. All residents in wheel chairs were screened for proper positioning. Element 3 The pain protocol was updated to reflect current standards of care. Moderate to severe pain levels will be addressed immediately. Regular use of PRN pain	

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2 830	Continued From page 15 eating. The MDS also indicated R25 received scheduled pain medication, received non-medical interventions, and had pain occasionally. The MDS identified diagnoses including: rheumatoid arthritis, chronic pain syndrome, osteoporosis, stage 3 kidney disease and transient ischemic attacks (TIA). The 7/24/2014, Pain Care Assessment (CAA) indicated R25 had arthritis and pain varied. R25's care plan last revised 8/5/14, indicated R25 rated her pain on a scale of 1-10 and as needed (PRN) medications may be given if indicated. Interventions indicated R25 was to participate in ambulation and exercises to decrease pain. No other pharmalogical interventions were addressed. The 6/12/2014, Pain Data Collection Assessment summary indicated R25 utilized a scheduled Fentanyl (narcotic medication) patch 25 micrograms (mcg) which was to be changed every 72 hours and Percocet 5/325 (narcotic medication to treat moderate to severe pain) milligrams (mg) PRN which was taken daily 4 out of 5 days. The assessment further indicated R25 had pain related to childhood rheumatoid arthritis, R25 participated in activities, ambulated to the toilet and also ambulated with staff. The assessment indicated the medication regimen was adequate for pain management and that staff should continue current care plan. The 6/25/14, therapy progress note indicated R25 was doing very well although ambulation distance varied due to pain in her legs, back, hands and neck from arthritis pain and directed the continuation of ambulation as tolerated.	2 830	medications will be evaluated for a more appropriate pain regimen. Education was provided to nursing staff. Therapy educated nursing staff on wheel chair positioning. Element 4 All residents will be evaluated for pain by nursing staff at least every shift on going. DON or designee will monitor 20% of MARs for excessive PRN use and moderate to severe pain levels weekly x 4 weeks, then monthly for 2 months, and thereafter quarterly. DON or designee will monitor all residents in wheel chairs for appropriate positioning daily x 7 days, then weekly x 3 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly. □	

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2 830	Continued From page 16 The 8/12/14, physician order indicated R25 was started on oxycodone (Percocet) 5/325 mg. one tablet every four hours PRN. The 9/2/2014, physician order indicated an increase of Fentanyl (Duragesic) to 50 mcg patch (previously 25 mcg) and to change every 72 hours for 30 days. The electronic medication administration record (EMAR) lacked monitoring and assessment of the efficacy of the increase in R25's Fentanyl patch. The 9/15/14, physician note indicated R25 stated her legs hurt and indicated R25 had 2 plus peripheral edema bilaterally which she'd had for a long time. The note indicated the edema was a little worse and more uncomfortable for her. The note also indicated R25 had severe deforming rheumatoid arthritis. The physician's plan indicated R25 had not previously utilized diuretics, that the elevation of her legs was not taking care of the edema, and that it had become symptomatic for her. Plan to get a baseline BMP (basic metabolic panel- lab work) and another one on Friday and start her on Demadex (diuretic) 10 mg every day and to monitor weights. The 9/24/14, nurse progress note by licensed practical nurse (LPN)-B indicated R25 had complained of severe left leg pain in the p.m. (evening), and that PRN Percocet 5/325 had been given at 4:40 p.m. and 10:30 p.m., with minimal relief after the 1st dose. The progress note indicated the nurse had noted R25's left leg was very swollen, from foot to hip. The record lacked documentation of the effectiveness of the 2nd dose of the PRN that had been given to R25.	2 830		

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2 830	Continued From page 17 The 10/2/2014, physician's order report indicated R25's current medications included: methotrexate sodium (used to treat severe rheumatoid arthritis) 25/ml (milliliters) injection every 7 days, Fentanyl patch every 72 hours 50 mcg/hr (hour), change every 3 days, Demadex 10 mg every day, Percocet 5/325 mg 1 tablet every 4 hours PRN, acetaminophen 325 mg two tablets PRN every 4 hours for minor or breakthrough pain and give between scheduled Percocet doses if needed. Do not exceed 3000 mg [acetaminophen] total in 24 hours. The EMAR dated 9/2/14-10/2/14 revealed the following: -R25's PRN Percocet had been used every day on average of 3 times a day and was up to 5 times in one day, with a total of 93 doses administered. -PRN Percocet was given for bilateral pain for lower extremity discomfort. -R25's PRN pain medication was effective 17 out of the 93 doses, "somewhat effective" 10 out of the 93 doses, not effective 1 out of the 93 doses, and 55 out of the 93 doses the effectiveness was lacking on the medical record. During interview on 9/30/2014, at 7:42 p.m. R25 stated she had discomfort in both of her legs. Review of the EMAR indicated on 10/1/14, at 1:57 a.m. PRN Percocet 5/325 mg. one tablet was given due to left leg and right and left heel pain. Documentation on effectiveness was lacking. During interview on 10/1/2014, at 7:05 a.m. R25 was observed lying in bed moaning "oh my leg hurts." Surveyor asked her if she had told	2 830		

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2 830	Continued From page 18	2 830		

anybody and she stated, "No, they know and all staff are busy." At 7:15 a.m. R25 stated both of her legs hurt, "they are hard as a rock, just feel them." At that time R25 removed her covers and showed the surveyor her legs that appeared shiny and firm to the touch.

At 7:45 a.m. nursing assistant (NA)-D was observed assisting R25 wash up for the day. R25 stated her groin/crotch area was swelled up and so tight. At 7:50 a.m. R25 stated as she transferred from toilet to wheelchair, "oh my knees hurt." NA-D stated, "Oh that darn arthritis." NA-D handed her a pair of slacks and R25 started to put on the pants with NA-D's assistance. R25 stated, "ouch" then stated the pants were too tight. NA-D offered her 3 different pair of pants due to each pair being too tight. R25 moaned in discomfort as she attempted to put on each pair of pants. R25 stated, "My legs are bad." R25 added, "Oh it hurts me." NA-D stated at that time (8:00 a.m.) R25 usually dresses herself but that morning she needed help getting out of bed because of her leg discomfort. NA-D was not observed to notify the nurse of the pain.

At 8:15 a.m. R25 stated her legs hurt and added, "They don't stop hurting." NA-D wheeled her to the dining room.

On 10/1/14, at 8:27 a.m. LPN-A gave R25 PRN Percocet 5/325 mg. for pain. R25 rated her pain at an 8.

At 8:50 a.m. R25 had finished eating her breakfast and at 9:00 a.m. R25 asked RN-A for a pain pill. LPN-A stated she gave her a pain pill 25 minutes ago and RN-A stated she should give the pain pill a while to work because she had just had her breakfast.

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2 830	Continued From page 19 At 11:25 a.m. NA-D stated R25 always had pain in her legs. NA-D stated it did not make a difference if she had taken a pain medication or not, R25 was always in pain. At 12:55 p.m. R25 stated,"[the pain pills] helped this morning for about two hours." R25 added, "They [her legs] hurt, they hurt, they hurt!" At 1:05 p.m. R25 told the director of nursing (DON) her legs hurt. At 1:07 p.m. LPN-A gave PRN Percocet 5/325 mg. tablet for pain in her legs, rating the pain at a 9. On 10/1/14, at 1:07 p.m. LPN-A stated staff can tell if R25's pain pills were effective or not, staff don't ask R25 if the PRN pain pills were effective because that was "like planting in her the need for another pain pill." LPN-A stated staff wait for her to ask for another pain pill. LPN-A stated NA-D did not inform her that R25's legs hurt on the morning of 10/1/14. LPN-A stated NA-D should have reported to her and R25 should have had a pain pill before getting out of bed. LPN-A added, "It has been very crazy around here." LPN-A stated R25 did not receive the PRN acetaminophen for breakthrough pain probably due to the staff did not want R25 to exceed the recommended amount of 3000 mg, since Percocet also has acetaminophen. On 10/2/14, at 9:30 a.m. LPN-B stated R25 was doing terrible with her pain management for her legs. LPN-B stated the medications did not seem to help. LPN-B stated she had not been giving R25 the PRN acetaminophen for break through pain and did not know why they did not give it.	2 830		

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2 830	Continued From page 20 On 10/2/14, at 9:30 a.m. registered nurse (RN)-B stated NA-D should have contacted LPN-A regarding R25's pain and before starting a.m. cares. RN-B verified R25 had used PRN Percocet 2-3 times a day and she questioned if it should be given on a regular basis. RN-B stated the physician would be contacted and verified the break through PRN acetaminophen should be given as directed by the physician. RN-B stated the staff could be doing some monitoring of R25's pain on a daily basis for the effectiveness of her current pain medications. RN-B added if staff were reporting that R25's pain was terribly managed, the information needed to be relayed to the DON. On 10/2/14, at 11:20 a.m. LPN-B stated R25's PRN Percocet usually was effective for a while but then R25 would state, "Old Arthur hurts." LPN-B stated last night LPN-D gave R25 a PRN Percocet around 2:00 a.m. and then 2 hours later R25 was asking for another pain medication, however, did not give her anything. LPN-B stated due to the fact R25 was on the bumped up dose of Duragesic patch, staff were concerned about her being a fall risk because she did get up by herself. On 10/2/14, at 11:55 a.m. the DON and RN consultant were interviewed. The DON stated the break through PRN acetaminophen needed to be implemented as directed by the doctor. On 10/2/14, at 2:30 p.m. RN-B provided the surveyor with a physician order dated 10/2/14, indicating R25 was to have an X-ray of bilateral hips, make appointment with physician to see if resident qualified for steroid injection in hips- left was worse than right, to schedule Tylenol 325 mg	2 830		

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2 830	Continued From page 21 2 tabs by mouth three times a day, ace wraps to lower extremities, and to increase Demedex to 15 mg every day. R6 was experiencing chronic pain on daily basis which affected her ability to participate in activities of daily living, without adequate assessment of the pain and/or efficacy of the narcotic medication. In addition, non-pharmacological interventions were not implemented to help alleviate pain. R6's annual MDS dated 3/3/14, indicated R6 had intact cognition and required extensive staff assistance for all activities of daily living. The MDS also indicated during the annual assessment period, R6 had reported her pain level at a 5 on a 0 to 10 pain scale. The assessment indicated the pain limited R6's ability to participate in day to day activities. R6's Pain CAA dated 3/13/14, indicated R6 voiced complaints of leg pain daily. R6 was on scheduled pain medications and received PRN medication for break through pain. R6's pain was attributed to cerebral palsy, muscle dystrophy and muscle spasms. The CAA also indicated staff assisted her to take frequent rest periods throughout the day and to keep the physician informed of the pain management program. R6's quarterly MDS dated 9/3/14, also indicated R6 had intact cognition, required extensive staff assistance with all activities of daily living and was unable to ambulate. The MDS indicated R6 had diagnosis including cerebral palsy, anxiety, diabetes mellitus and congestive heart failure. The MDS also indicated R6 suffered from	2 830		

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2 830	Continued From page 22 frequent pain which prevented her from participating in daily activities. During the assessment period, R6 had reported her pain to be at a 6 on a 0-10 pain scale. R6's care plan dated 6/4/14, identified an alteration in comfort related to numbness/tingling in the hands secondary to carpal tunnel syndrome and muscle spasticity secondary to cerebral palsy. The plan directed staff to anticipate her needs and respond in a timely manner. The care plan did not direct staff on how to minimize potential leg pain and it did not include non-pharmacological interventions to minimize R6's pain. The physician note dated 7/3/14, indicated R6's biggest problem was related to pain control. The note also indicated at that time, R6 was watching the clock and asking for frequent pain medications. The physician had initiated use of a Fentanyl patch for R6 and indicated the staff were to monitor for pain control and anxiety related to the pain medications. The physician identified a plan to continue to make pain medication changes if this was not effective. R6 was seen by the physician on 8/5/14, 8/8/14 and 8/12/14, for an acute infection, those progress notes did not address R6's pain. During a visit on 9/5/14, the physician noted, "Will continue with her current pain medications, which are working pretty well for her." The Physician Order Report dated 9/5/14, included Baclofen (muscle relaxer) 10 mg three times a day, Gabapentin (medication used to treat nerve pain) 300 mg three times a day, and Tylenol extra strength 500 mg one tablet every	2 830		

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2 830	Continued From page 23 four hours as needed for pain. In addition, on 7/6/14, the physician had added Fentanyl (medicated pain patch) 25 mcg/ hour to be changed every three days. The facility completed a Pain Data Collection for R6 on 8/30/14 - 9/3/14, 5/31/14 - 6/4/14, 2/27/14 - 3/31/14, and 11/27/13 - 12/1/13. The data collection tools indicated R6 experienced pain daily. After each pain data collection period the registered nurse completed a review of R6's pain. The summary repeated the current pain medications, indicated R6 had voiced concerns of pain daily and directed staff to assist with comfort via as needed pain medications, repositioning, occupational and physical therapy interventions. However, the summaries did not address R6's response to the current medication regimens. In addition, the clinical record lacked indication whether the addition of the Fentanyl patch started on 7/6/14, was effective. Review of the resident progress notes (nurse's notes) indicated the following information: - 7/10/14, at 3:29 a.m. R6 was complaining of pain more frequently this shift. She is currently on Tylenol prn which she had received at 6:00 p.m. and 11:23 p.m. R6 continued to holler out and request pain pill frequently (every 15 minutes) throughout the night shift. R6 was repositioned with relief lasting 15-30 minutes before she would request additional medications. -7/17/14, at 3:33 a.m. R6 received Tylenol 500 mg at 3:00 am. R6 complains of pain responds well to repositioning and massage as non-pharmacological therapy. - 7/31/14, at 2:57 a.m. R6 had Tylenol 500 mg at	2 830		

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2 830	Continued From page 24 1:30 a.m. Non-pharmacological interventions used before resident was due for PRN included light massage, reposition and range of motion with the affected leg. -8/17/14, at 5:11 a.m. R6 requested Tylenol one time. No further follow up was noted. - 8/28/14, at 6:41 a.m. R6 received Tylenol 500 mg for leg pain. The note lacked follow up to the pain. On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh." No staff members were observed in the dining room as R6 cried holding her head. A few moments later NA-A walked up to R6 and escorted her to her room. At 9:15 a.m. R6 was observed resting in bed. On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head. At 9:05 a.m. NA-A wheeled R6 to her room. At 9:10 a.m. NA-A stated R6 cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication. On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will	2 830		

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2 830	Continued From page 25 ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain as a "toothache that never goes away." She stated the pain prevented her from participating in many of the activities in the facility because sometimes it was better in the chair... and other times it was better in bed. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is receiving her pain medications. On 10/2/14, at 10:00 a.m. NA-D stated R6 expressed pain in her left leg every day. She stated she attempts to reposition R6 in bed or rub her leg, but it usually does not give R6 extended relief. She stated R6 may have a few moments of pain relief, but it did not last long. She reports the pain to the nurses. Review of the EMAR revealed the following information: 7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol. 7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol. 8/1/14 - 8/31/13, R6 received 81 doses of PRN Tylenol 500 mg. 9/1//14 - 9/30/14, R6 received 98 doses of PRN Tylenol 500 mg. 10/1/14- 10/2/14, R6 had received 6 doses of PRN Tylenol 500 mg.	2 830		

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2 830	Continued From page 26 The reason documented for the medication was "pain" or "leg pain." The medication was noted to be "effective" or "somewhat effective." On 10/2/14, at 10:10 a.m. LPN-B stated R6 reported complaints of pain "all of the time." She stated R6 will request pain medications and will watch the clock waiting for the four hours to pass before she can ask for the next pill. LPN-B stated R6 was uncomfortable, "I wish we could find something to giver her relief." LPN-B stated when she would administer R6's pain medications she followed up with R6 by visually looking at her. She stated if the nurse were to ask her how her pain was, she would just ask for more medications. LPN-B added if R6 looked like she was not in pain, they write effective or somewhat effective. She confirmed she did not discuss pain relief with R6. On 10/2/14, at 11:00 a.m. R6's pain was reviewed with the interim DON and the consultant RN. The interim DON stated she was aware R6 expressed pain daily. The two RNs reviewed R6's clinical record and were unable to find indication in which the staff had completed a comprehensive assessment of R6's pain and were unable to determine if the Fentanyl which had been added in 7/2014, was an effective medication for controlling the pain. On 10/2/14, at 11:20 a.m. the consultant RN confirmed R6 experienced pain daily and had not been comprehensively reassessed by the nurses to determine the extent of the pain. She stated the facility had not exhausted resources to reduce R6's pain. She confirmed R6 had not consistently received non-pharmacological interventions to minimize pain and she continued to express pain.	2 830		

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2 830	Continued From page 27 She stated she was aware R6 was utilizing PRN medications for the treatment of pain but was not aware she was utilizing over 70 PRN medications per month. At that time the RN consultant was asked to review R6's medication regimen to determine a timeline of pain medication changes in the past 6 months. On 10/3/14, at 8:50 a.m. the consultant RN stated she had interviewed R6 and confirmed R6 expressed continued pain. She stated she did not find it helpful to review R6's record to determine what had been attempted in the past, but felt it was better to take the time and move forward and treat R6's pain. The consultant RN provided a Patient Comfort Assessment Guide dated 10/3/14, which confirmed R6 continued to express daily pain. R11 was experiencing moderate to severe chronic pain on daily basis which affected her ability to participate in activities of daily living without adequate assessment of the pain and / or efficacy of the narcotic medication nor consistent implementation of non-pharmacological interventions to help alleviate the pain. R11's Physician Order Report dated 9/3/14-10/3/14, indicated R11 had diagnoses that included osteoporosis (a disease in which bones become fragile and more likely to fracture), lower leg osteoarthritis (degenerative arthritis affecting the cartilage), chronic pain, restless leg syndrome and Wegener's granulomatosis (causes inflammation of the blood vessels). R11's significant change MDS dated 8/11/14, indicated R11 had severe cognitive impairment	2 830		

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2 830	Continued From page 28	2 830		

and required extensive assistance of one staff for locomotion on and off the unit, dressing and personal hygiene and limited assistance of one staff for bed mobility, transfer, ambulating in room and corridor and toilet use. The MDS also indicated R11 received scheduled and as needed pain medication and non-medication interventions for pain. The MDS also indicated R11 reported her pain as moderate and frequent but it did not interfere with daily activities or make it difficult to sleep at night. The MDS further indicated R11 received physical therapy (PT) and occupational therapy (OT) services and received active range of motion (ROM) restorative nursing services.

R11's quarterly MDS dated 7/12/14, indicated R11 had moderate cognitive impairment and required limited assistance of one staff for bed mobility, transfers, dressing and toilet use and supervision of one staff for ambulating in room or corridor, locomotion on and off the unit, and personal hygiene. The MDS also indicted R11 received scheduled and as needed pain medications and non-medication interventions for pain. The MDS also indicated R11 reported her pain as moderate and frequent but it did not interfere with daily activities or make it difficult to sleep at night. The MDS indicated R11 did not receive PT, OT or restorative nursing services.

R11's pain CAA dated 8/23/14, indicated R11 remained at risk for ongoing pain, increase in pain and unrelieved pain due to debilitating effects of chronic disease. The CAA indicated R11 reported pain to lower back, knees and joints and described it as an "achy, arthritic pain," remained alert and able to communicate needs effectively and appropriately and could alert staff if and when in pain. The CAA indicated staff was to observe and report any non verbal indicators of

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2 830	Continued From page 29 pain. Finally, the CAA indicated R11's pain was chronic in nature and required scheduled and PRN analgesics to maintain optimal comfort level. R11's Activities of Daily Living / Functional Rehabilitation CAA dated 8/23/14, indicated R11 remained at risk for further on going decline due to progression of chronic disease processes resulting in a past history of falls, chronic pain and functional urinary incontinence. The CAA indicated R11 had returned to baseline since hospitalization for pneumonia and indicated staff was to continue to assist with ADL and mobility as needed and report changes in ability and tolerance. The CAA also indicated anticipation of on going fluctuation of physical function and tolerance based on potential exacerbation of chronic disease processes. R11's care plan dated 7/17/14, identified R11 had alteration in comfort related to pain secondary to history of compression fractures of her back and indicated R11 would verbally state pain was 2-3 on a verbal scale of 0-10 after administration of pain medication. The care plan directed staff to administer medications as ordered for pain and to monitor for effectiveness of pain medications and possible side effects. The care plan did not identify or address R11's knee/joint pain, nor did it identify non-pharmacological interventions for pain. Review of R11's medical record revealed the following history regarding the ongoing management of R11's knee pain:	2 830		

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2 830	Continued From page 30 The RN Assessment Summary dated 1/13/14, on the Pain Data Collection form dated 1/8/14, to 1/12/14, indicated R11 had denied pain during the assessment period and R11 received scheduled Lortab (hydrocodone-acetaminophen)(a narcotic pain reliever for moderate to severe pain) 10-500 mg three times daily and Lidoderm patch (a local anesthetic) to lower back daily. It also identified R11 could also have PRN Lortab for breakthrough pain though she had not received any during the assessment period. Non-medication interventions to pain included repositioning, exercise/ROM, activities and 1:1 visits. R11's pain was assessed as controlled with medication and interventions at that time. The physician progress note dated 2/25/14, identified R11 had a chief complaint of right knee pain with weight bearing for 1 week. It also identified R11 had a history of degenerative joint disease and R11 had last had an injection months previous that had helped "for a long time." The progress note further indicated R11 received a cortisone injection to her right knee at the visit. The physician progress note dated 3/10/14, indicated the visit was for follow up on R11's right knee pain and identified R11 reported some relief of that pain with the cortisone injection but not for very long. R11 continued to report pain with weight bearing and stated it hurt even while in bed at times. The progress note also identified R11 had been taking Lortab on a scheduled and PRN basis. R11 reported the medication worked for a while but wore off. The physician assessment identified right knee pain with degenerative joint disease, transient response to cortical steroid injection with constipation likely	2 830		

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2 830	Continued From page 31 related to activity and pain medications. The progress note identified the physician's plan was to increase R11's laxatives and switch her to a Fentanyl patch from scheduled hydrocodone, 12.5 micrograms (mcg) per hours equivalent to her current dose of 30-40 mg per day of hydrocodone. The physician's telephone orders dated 3/10/14, included the following: change Lortab 10-500 to Norco (hydrocodone-acetaminophen)(a narcotic pain reliever for moderate to moderately severe pain) 5-325 mg one by mouth three times a day as needed, trial of Fentanyl patch 12.5 mcg change every 3 days and discontinue scheduled Lortab. The RN Assessment Summary dated 4/13/14, on the Pain Data Collection form dated 4/7-4/11/14, R11 had reported pain almost daily during the look back period and identified R11 was on scheduled pain medication and took PRN medication frequently with effective results. The summary also indicated R11 was encouraged to ambulate and be as active as possible and during this time a knee brace being worn was discontinued due discomfort. The summary further identified R11 had a recent pain medication change which seemed more effective. The Memo To Physician dated 4/18/14, identified R11 was needing to take her PRN Norco three times a day nearly each day and still complained of pain. The memo asked if the medication could be given more often for R11's breakthrough pain. The physician response dated 4/21/14, was an order for Norco three times per day with Norco	2 830		

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2 830	Continued From page 32 twice a day PRN for breakthrough pain. The Memo to Physician dated 6/1/14, identified R11 appeared to be more drowsy and lethargic and questioned confusion. The memo asked if they could consider going back to increased dose of Vicodin (hydrocodone-acetaminophen) or oral morphine versus Fentanyl. The memo indicated R11's family had concerns with Fentanyl and wanted the physician to consider MS Contin (time-released morphine usually taken every twelve hours for chronic pain) and an increase of R11's Norco back to 10-325 [sic] four times a day and twice a day as needed. The physician response dated 6/12/14, indicated "we'll see how she responds to increased Zoloft" (an antidepressant). The Nursing Home Note dated 6/12/14, identified R11 was seen for bilateral hearing loss and indicated mood wise R11 still had some dysphoria. R11 was not sure if this was related to vision and hearing issues or just mood. The note identified R11 was on 12.5 mg per day of Zoloft that was helping. The note also identified there had been some concern about increasing confusion and there had been some discussion about switching back from Fentanyl to Norco. The note further identified R11 had only taken 3 PRN Norco in the past 2 weeks while on the Fentanyl. The physician's impression was some concern for intermittent confusion and indicated he would hold off on the Fentanyl change at that time. The impression also indicated a possible mood issue and the physician increased her Zoloft from 12.5 to 25 mg per day.	2 830		

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2 830	Continued From page 33 The Nursing Home Note dated 7/8/14, indicated R11's family was very concerned her decline in status might be related to medications, specifically Fentanyl. The physician impression indicated he felt R11's mental status changes were possibly related to depression and likely related to her vision and hearing loss. The physician's plan was to lower gabapentin (for restless leg syndrome) from four times a day to twice a day and hold R11's Fentanyl. The physician indicated morphine was an option down the road if R11 did well off of the hydrocodone. Other options identified were discontinuation of gabapentin altogether or increase or decrease of R11's Zoloft dose. The Physician's Telephone Orders dated 7/8/14, included decrease gabapentin to 300 mg twice day and hold Fentanyl patch trial for one week. The RN Assessment Summary dated 7/14/14, on the Pain Data Collection form dated 7/8/14 -7/12/14, identified R11 reported moderate pain daily and indicated the physician was trying to balance pain control and symptoms of confusion. The RN repeated the current pain medication regimen and indicated they would continue to work with the physician for pain control. The assessment did not identify non-pharmacological interventions for pain. The Physician's Telephone Orders dated 7/15/14, discontinued gabapentin and discontinued Fentanyl patch. The Nursing Home Note dated 7/29/14, indicated	2 830		

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2 830	Continued From page 34 R11 was seen regarding family concerns related to pain, delirium, hearing and intake issues. The physician's impression included pain issues with vertebral compression fractures and arthritis. The physician's plan identified R11's family was wondering about morphine. The physician indicated he was considering a referral to hospice for their advice. His plan further indicated he would not change medications until R11's shortness of breath (identified upon physician examination) was evaluated. R11 was hospitalized from 7/31/14, through 8/4/14 for pneumonia. The facility completed Pain Data Collection for R11 on 8/5/14 - 8/9/14. The RN assessment summary of the data collection completed on 8/13/14, identified R11 had complained of pain during the assessment period. The RN repeated the current pain medication regimen and indicated R11's pain was rated as mild and the current regimen was meeting R11's needs. The assessment summary did not address non-pharmacological interventions for pain. The Physician Order Report dated 9/3/14-10/3/14, included orders for Lidoderm adhesive patch 5% mg/patch), apply 1 new patch topically to mid-back daily on 12 hours and off 12 hours for chronic pain, Norco 5-325 mg three times a day (scheduled dose), Norco 5-325 mg 1 tab twice a day PRN for pain, and acetaminophen 500 mg 1 tab every 6 hours PRN for pain. The report also included an order for heat or ice to right knee for comfort as needed on for intervals of 10 minutes with a start date of 3/17/14.	2 830		

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2 830	Continued From page 35 The Nursing Home Note dated 10/1/14, indicated R11 was seen by the nurse practitioner for right knee pain. R11 reported discomfort with walking. The nurse practitioner's plan was to apply ice or alternate heat and ice, continue with pain medications on the MAR (medication administration record) and participate in activities as tolerate. R11's Medication Administration History dated 8/8/14 -10/3/14 revealed: -Lidoderm adhesive patch 5% was administered early at R11's request 30 of 57 days. -Norco 5-325 mg three times a day (scheduled dose) was given early for the morning dose on 8/25, 9/12, 9/22, 9/25, 9/26, 9/29, 9/30, 10/1, 10/2, and 10/3 and for the afternoon dose on 9/9 (11 doses). R11's PRN Medications Administration History 8/8/14-10/3/14 revealed: -Norco 5-325 mg 1 tab twice a day PRN, 32 doses were given on 29 of 57 days for complaints of pain in knees or legs. 24 of 31 doses were given between the hours of 12:55 a.m. and 4:52 a.m. 4 doses were given between the hours of 9:42 a.m. and 2:29 p.m. and 3 doses were given between the hours of 11:01 p.m. and 11:31 p.m. The medications were assessed to be effective or somewhat effective except for one dose given on 9/28 which was assessed to be not effective and R11's next scheduled dose of Norco was given early. -acetaminophen 500 mg 1 tab every 6 hours as needed was given once on 8/8, 8/30, and 9/3 and given three times on 10/2 for complaints of	2 830		

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2 830	Continued From page 36 pain in knees or legs. The medications were assessed to be effective R11's Treatment Administration History 8/8/14-10/3/14 revealed: -Heat or ice to right knee for comfort as needed for intervals of 10 minutes was not documented on the treatment record during this time period. The resident progress note dated 10/1/14, at 11:23 p.m. indicated an ice pack was applied to R11's right knee two times during the shift. R11 stated, "It feels better" however, within 1-2 hours complained of breakthrough pain. On 10/2/14, at 9:04 a.m. R11 was observed in her room seated in a recliner. R11 stated she had been having a lot of problems with her right knee and raised her pant leg above her knee and began to rub it. The knee was observed to be swollen. R11 stated she was given pain pills for the knee pain and that they lasted a little while "but they don't last forever." She stated that on 10/1/14, she was given cold packs, as well, and that helped for a little bit. R11 stated the pain kept her up at night at times and that the previous night she was "up a lot" until she finally got a pain pill. R11 stated the pain medication lasted for about 4 hours before her knee began hurting again. R11 also stated she asks for a pain pill a couple of times a day and identified her pain at that time at an 8 out of 10. R11 stated she also received cortisone shots from the physician and they lasted for about a month but the pain always came back. R11 further stated she was due for her bath today and the whirlpool tub also felt good on her knee.	2 830		

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2 830	Continued From page 37 On 10/02/2014, at 9:36 a.m. R11 was observed ambulating down the hall with wheeled walker from her room to the bath room. Her gait was slow and R11 was observed to favor her right side. On 10/02/2014, at 10:02 a.m. R11 was observed ambulating back toward her room after her bath. R11 was observed to be limping on her right leg. R11 stated her knee felt much better after her whirlpool bath. On 10/2/14, at 10:43 a.m. R11 was observed seated in her room in a recliner with a wheeled walker in front of her chair. R11 stated the pain limited her activities during the day and prevented her from joining in. She stated, "I just can't do it." R11 stated her knee currently still ached and was a 7 out of 10 on a 1 to 10 pain scale. R11 stated her knee hurt all the time but it was alright if she sat "absolutely still." R11 further indicated walking made her knee feel worse. On 10/02/2014, at 10:48 a.m. NA-B stated R11 had pain daily and may have had more pain lately since recently bumping her right knee. NA-B indicated R11 would go to some activities if she felt up to it and attended therapy [restorative nursing] three times a week and would tell them if her right knee bothered her too much so they then did not do exercises on that leg. On 10/02/2014, at 10:55 a.m. NA-D stated R11 had pain every day and received pain medication	2 830		

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2 830	Continued From page 38 for the pain. NA-D indicated she was not aware of any non-pharmacological interventions for the relief of R11's pain nor was she aware of factors that aggravated R11's pain. NA-D stated R11 spent most of her time in her room and only came out for meals or a bath. NA-D also stated R11's family used to bring her out to the common area to visit and have coffee, however they no longer did this when they visited. NA-D further indicated R11's pain was mostly in her knees. On 10/02/14, at 11:05 a.m. NA-C stated she worked with R11 with restorative nursing exercises to both upper and lower extremities. NA-C confirmed R11 had pain in her right knee. Review of the restorative nursing sheets for August 2014, and September 2014, revealed R11 had not refused exercises to the right lower extremity. On 10/02/2014, at 2:39 p.m. licensed practical nurse LPN-B stated R11 received scheduled pain medication three times a day and could also have PRN pain medication for her knee pain. She stated if R11 asked for extra pain medication, it was usually needed on the night shift but was occasionally given during the day. LPN-B stated PRN Norco was usually given. LPN-B stated she did not specifically ask R11 how effective the pain medication was or asked R11 to rate her pain using the 1-10 pain scale after medication was given. LPN-B stated sometimes asking a resident about pain medication would prompt them to ask for additional medication. LPN-B stated instead she would simply observe for effectiveness or have general conversation with R11 and see if she complained of further pain. LPN-B indicated R11 had used warm packs on	2 830		

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2 830	Continued From page 39 her legs before but stated they had only done so very occasionally and it had been about a month since the warm packs had been used. LPN-B indicated that the warm packs had been effective and R11 had liked the warm packs when used in the past. When asked why they stopped used warm or cold packs for R11's knee pain, LPN-B stated "sometimes you get complacent". LPN-B indicated that currently if R11 indicated she was in pain and had just had a pain pill, they instructed her to elevate her legs and take it easy until the medication worked. Additionally, LPN-B stated R11 stayed in her room quite a bit, but came out occasionally for activities. On 10/02/2014, at 3:12 p.m. interim DON and consultant RN confirmed hot/cold packs should have been used as a non-pharmacological intervention for R11's knee pain and R11's pain should have been reassessed upon her return to baseline functional ability after her hospitalization. On 10/3/13, at 8:55 a.m. the consultant RN provided a Patient Comfort Assessment Guide dated 10/3/14 which confirmed R11 continued to express continuous pain that only went away with pain medication. The facility's undated Pain Assessment Policy, directed staff to assess the resident's pain level and provide optimal comfort through a pain control plan which was mutually established with the resident, family and members of the health team. The policy directed staff to assess the resident's pain, develop pharmacological and non pharmacological interventions to reduce the pain and to contact the physician of any unrelieved	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 40 pain. R31 was not provided leg rests on the wheelchair to ensure appropriate positioning. R31's admission MDS dated 8/23/14, indicated R31 was cognitively intact, was independent with wheelchair locomotion, transferring and was non-ambulatory. R31's Fall CAA dated 8/23/14, indicated R31 had a puncture wound on her left foot, was non- weight bearing and could safely transfer self from the bed to the wheelchair and back. On 9/29/14, at 6:10 p.m. R31 was observed in her wheelchair self propelling with her hands. R31's feet were observed dangling unsupported about eight inches from the floor. There were not leg rests observed on the wheelchair. On 9/30/14, at 8:46 a.m. R31 stated they did not provide her with wheelchair leg rests. At 2:26 p.m. R31 was observed self propelling her wheelchair with her hands. Her left foot was in a walking boot and her right foot was about eight inches from the floor. At 2:56 p.m. R31 was observed self propelling herself in the wheelchair back to her room. R31 was able to use her left foot that was in the walking boot to help with propelling. R31's toes of her right foot were observed to touch the floor. The wheelchair was not equipped with leg rests. At 3:45 p.m. R31 was observed in her wheelchair at a table playing a game. Her right heel remained unsupported and dangling about eight	2 830		

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	00296	A. BUILDING: _____ B. WING _____	10/03/2014

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2 830	Continued From page 41 inches from the floor. On 10/1/14, at 8:10 a.m. R31 was observed in her wheelchair. R31 had a blue surgical bootie on her left foot dressing and a sock on her right foot. R31's feet were observed unsupported and dangling about eight inches from the floor. At 8:20 a.m. registered nurse (RN)-A stated R31 was admitted in a wheelchair. RN-A stated neither physical therapy (PT) or occupational therapy (OT) had seen R31. RN-A stated R31 was so independent with self propelling her wheelchair with her hands. RN-A stated she had not noticed that R31's feet did not touch the floor. At 11:20 a.m. R31 stated the first wheelchair she had was equipped with leg rests and that chair was too wide for her to get into the bathroom. At this time OT-A stated R31 was up "way too high." OT-A stated her feet were eight inches from the floor. R31 stated she only used her hands to propel the wheelchair. OT-A told R31 they did not want her feet to dangle from the wheelchair. OT-A stated he would make wheelchair adjustments for proper wheelchair positioning. At 11:27 a.m. R31 stated since her first wheelchair was too wide for her, family member (FM)-A found this current wheelchair in the hallway and gave to her to use about two weeks ago. On 10/2/14, at 8:21 a.m. nursing assistant (NA)-C stated if she were to see a resident that did not have proper wheelchair positioning she would notify OT. NA-C stated she had not worked for the past 3 weeks. At 9:17 a.m. the consulting registered nurse (RN)	2 830		

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2 830	Continued From page 42 stated there was not a policy related to proper wheelchair positioning. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could review and revise the policy and procedures related to pain and pain management. Education could be provided to all of the involved staff members. A system could be established to provide ongoing auditing and education to all involved parties. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		11/12/14

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2 900	Continued From page 43 Based on observation, interview and document review, the facility failed to ensure a resident identified at risk for pressure ulcers received assistance with repositioning in order to prevent the development of pressure ulcers for 1 of 1 resident (R4) in the sample. Findings include: R4's diagnoses included a multiple sclerosis, cerebral palsy, stroke, and diabetes, according to the electronic medication administration record (EMAR). The quarterly Minimum Data Set (MDS) dated 9/6/2014, indicated R4 had cognitive impairment, required extensive assist from staff for bed mobility, transfers, and was non ambulatory. The MDS also indicated R4 was at risk for pressure ulcers. The 3/6/14, Pressure Ulcer Care Area Assessment (CAA) also indicated R4 was at risk for pressure ulcers due to incontinence and non-ambulatory. The care plan dated 9/11/2014, indicated R4 was to be turned and repositioned every 3 hours while in bed and 1 1/2 hours when up in her wheel chair due to risk for pressure ulcers. The care plan R4 had a pressure reducing cushion in her wheel chair. The 9/17/14, Braden Tissue Tolerance assessment indicated R4 was at risk for pressure ulcers due to immobility and incontinence.	2 900	Element 1 A tissue tolerance was performed on R4 and the pressure ulcer prevention care plan was updated to reflect current standards of care. The resident remains at base line without skin breakdown. Element 2 All residents at risk for skin breakdown were reassessed for bed, wheelchair,and general positioning and tissue tolerance. The care plans were updated as necessary and implemented/communicated per POC kiosks throughout the facility. Element 3 Pressure ulcer prevention protocol was updated as appropriate and educated to nursing staff. Element 4 Residents dependent for bed wheelchair, and general positioning will be monitored for repositioning by the nurse on duty daily. The DON/designee will audit weekly x 4 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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2 900	Continued From page 44 On 10/1/14, at 7:05 a.m. R4 was observed sitting in the dining room at the table. At 7:30 a.m. R4's son stated she had been up in the chair when he came to see her at 6:45 a.m. From 7:50 a.m. to 8:50 a.m., R4 was observed to continue sitting at the table in the dining room. At 8:50 a.m. R4 finished her breakfast. At 9:25 a.m. R4 was wheeled to the bathroom and transferred to the toilet. R4's skin to the buttocks was observed intact with slight redness. On 10/1/2014, at 9:30 a.m. when asked by surveyor, NA-H stated R4 was placed in her wheel chair at 6:30 a.m. and had not been repositioned or toileted since that time (2 hours and 55 minutes without repositioning). NA-H stated R4 was to be repositioned and toileted every 2 hours. On 10/1/14, at 12:20 p.m. registered nurse (RN)-A verified R4 was to be repositioned every 1 1/2 hours while in her wheel chair. Adding R4's care plan was not followed. SUGGESTED METHOD OF CORRECTION: The director of nursing could assign the interdisciplinary team to review all residents at risk for pressure sores to assure they are receiving the necessary treatment/services to prevent pressure sores from developing and to promote healing. The director of nursing could assign the Quality Assurance Committee to provide on-going monitoring of the delivery of care to residents to ensure that pressure sores do not develop unless the resident's clinical condition demonstrates that they were unavoidable.	2 900		

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2 900	Continued From page 45 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to administer medications via gastrostomy tube (G-tube) individually with appropriate water flushes for 1 of 1 residents (R33) who received G-tube medications Findings include: R33's Physician Order Report dated 8/5/14-10/14/14 identified diagnoses that included post concussion syndrome and gastrostomy (creation of an artificial external opening into the stomach for nutritional support or gastrointestinal	2 930	Element 1 The nurse who did not flush the G-tube with water between individual medications was educated regarding the correct policy regarding flushing with water between individual medications and return demonstration was verified. Element 2 All residents with G-tubes were assessed during medication pass for correct method per policy regarding flushing with water between individual medications.	11/12/14

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2 930	Continued From page 46 compression). During observation on 10/01/14, at 11:35 a.m. licensed practical nurse (LPN)-A dispensed an aspirin 81 milligram (mg) chewable tablet into a paper medication cup. She then measured 30 milliliters (ml) of lactulose solution 20 gram (gm)/30 ml into a plastic medication cup. LPN-A then dispensed a hydrocodone-acetaminophen 5-325 mg tablet into the paper medication cup with the aspirin. Finally, LPN-A drew 4 ml of potassium chloride 10% 20 milliequivalents (meq)/15 ml solution into a 10 ml syringe. LPN-A then placed the tablet medications into a plastic sleeve and crushed the medications, placed the crushed medications into a plastic water glass, and added 15 mls of warm water to dissolve the medications. LPN-A gathered the medications and gloves and entered R33's room. LPN-A donned the gloves and drew air into a 60 ml syringe. LPN-A stopped the tube feeding and checked the placement of the G-tube by listening as she instilled air into the G-tube. LPN-A then drew 30 mls of water into the 60 cc syringe and flushed the G-tube. Next, she drew lactulose into the syringe and instilled 1/2 the solution into the G-tube. LPN-A then drew 10 ml of water into the syringe with the remaining lactulose and instilled via the G-tube. LPN-A flushed the G-tube with 15 mls of water. Next, LPN-A drew the crushed medication and water solution into the syringe and instilled by depressing the plunger. She then flushed the G-tube with 15 ml of water. Next LPN-A squirted the potassium solution from 10 ml syringe into the plastic water glass and drew it into the 60 ml syringe, and instilled it into the G-tube. Finally, LPN-A flushed the G-tube with 30 ml water and restarted the feeding. LPN-A discarded her gloves, raised the head of R33's bed and washed her hands before exiting the	2 930	Element 3 The policy was reviewed and updated as appropriate. Licensed nurses were educated about the policy regarding flushing between individual medications when providing medications per G-tube. Element 4 The DON/designee will audit medication administration according to policy for all residents with G-tubes daily x 7 days, then weekly x 3 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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2 930	Continued From page 47 room. R33's Physician Order Report dated 8/5/14-10/15/14 directed staff to flush G-tube with 30 ml of water before and after each medication. The order did not direct the mixing of medications. On 10/01/2014, at 11:51 a.m. LPN-A stated that pharmacy had told them they could crush and give oral medications together. LPN-A stated she had not been instructed to give each medication separate with flushes between. On 10/03/2014, at 9:32 a.m. the consulting registered nurse (RN) indicated the facility had been instructed by pharmacy to either flush between each medication or flush before and after a group of medications as long as there are no incompatibilities between the medications given concurrently. On 10/03/2014, at 11:34 a.m. the consulting RN confirmed the physician orders called for 30 ml flush between each medication. The Enteral Tube Medication Administration policy date 4/23/14, directed crushed medications were not to be mixed together. Each medication was to be administered separately to avoid interaction and clumping. The enteral tubing was to be flushed with at least 5 ml of water between each medication to avoid physical interaction of the medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise policies and procedures for medication administration via gastrostomy tube (G-tube) and	2 930		

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2 930	Continued From page 48 could schedule an in-service for staff regarding medication administration. The Director of Nursing could delegate nursing staff to monitor compliance and report to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
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; 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.	21390		11/12/14

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21390	Continued From page 49 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to use proper infection control practices for 7 of 7 residents (R3, R2, R10, R32, R31, R6, R4) who used a blood glucose monitoring machine to check their blood sugar levels. In addition, the facility's infection control (IC) program lacked a surveillance program and investigation of infections for tracking trends and analysis of data to determine interventions to prevent the spread of infections. The lack of surveillance had the potential to affect 26 of the 26 residents who resided in the facility. Findings include: On 9/29/14, at 5:28 p.m. licensed practical nurse (LPN)-C applied gloves and obtained blood from R4's finger to check her blood sugar level with the blood glucose monitoring (BGM) machine. LPN-C stated they used the one facility BGM machine for all the residents who required blood sugar checks. LPN-C was observed to clean the BGM machine with a sani wipe towelette. The package information indicated the towelette contained the active ingredient 70% alcohol antiseptic. R3 had a physician's order dated 7/22/13, for blood sugar checks twice daily four days a week. R2 had a physician's order dated 9/19/14, for blood sugar checks daily. R10 had a physician's order dated 6/10/13, for blood sugar checks three times a day. R32 had a physician's order dated 9/25/14, for blood sugar checks four times a day. R31 had a physician's order dated 8/21/14, for	21390	Element 1 The facility reviewed the infection control surveillance program and found it had not completed after May 2014. Surveillance, including investigation, trending and analysis of data to determine interventions to prevent the spread of infections was completed for June, July, and August, 2014. The product used for cleansing the glucometer was immediately changed to an EPA approved germicidal cleanser. Element 2 The facility completed surveillance for September, 2014 and nursing is identifying infections and antibiotic use as they occur. An EPA approved germicidal cleanser is used on all glucometers in the facility. Element 3 The policy regarding IC surveillance was reviewed and the policy regarding cleansing of glucometers was updated as appropriate. Licensed nursing staff was educated regarding IC surveillance and cleansing of glucometers. An infection control nurse has been identified and trained regarding surveillance and glucometer cleansing. Element 4 The Administrator/Designee will audit IC surveillance monthly x 3 months and then quarterly ongoing. Variances will be reviewed at QAPI at least quarterly.	

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21390	Continued From page 50 blood sugar checks four times a day. R6 had a physician's order dated 12/6/13, for blood sugar checks daily. R4 had a physician's order dated 12/26/13, for blood sugar checks four times a day. On 9/29/14, at 5:41 p.m. LPN-C stated they were told they could not use the sani wipe clothes as they would damage the BGM machine. LPN-C stated they were instructed to only use the sani wipe towelettes and a sign indicating this was posted at the nurse's station. On 10/2/14, at 8:49 a.m. the interim director of nursing (DON) stated an employee from the laboratory stated not to use the sani wipe clothes to clean the BGM machine as it would damage it. At this time the consulting registered nurse (RN) stated she would check the manufacturer's instructions for the towelettes to determine the active ingredients. At 10:05 a.m. the consulting RN stated she was surprised that one individual from the laboratory would have made the decision to change the disinfecting product for the BGM machine. The consulting RN stated she had checked the manufacturer's instructions for the towelettes and reported they did not kill blood borne pathogens. The consulting RN stated they were changing their disinfecting product that day for the BGM machine back to the sani wipe clothes that do kill blood borne pathogens. The consulting RN stated the sani wipe towelettes only contained alcohol and inactive ingredients. At 10:45 a.m. the consulting RN stated she checked with the laboratory personnel and stated it had been about a month since the disinfecting product was changed.	21390		

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21390	Continued From page 51 SURVEILLANCE On 10/2/14, at 8:51 a.m. the consulting RN stated May 2014, was the last time surveillance of resident infections was done. The interim DON stated the RN who was doing the IC resident tracking had resigned and therefore the surveillance for residents had not been completed. The Surveillance of Health Care associated Infections policy revised 4/12, indicated the infection control officer would perform ongoing total or target house surveillance activities under the direction of the Infection Prevention and Control Committee. A policy was requested regarding the disinfecting of the accu check machine and none was provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review/revise policy for gulcolmeter cleaning. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist	21530		11/12/14

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21530	Continued From page 52 currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by:	21530		

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	00296	A. BUILDING: _____ B. WING _____	10/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD REHABILITATION & LIVING CEN	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

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21530	Continued From page 53 Based on observation, interview and document review, the consultant pharmacist failed to identify and report on the efficacy of pain medications for 2 of 3 residents (R6, R11) who had chronic pain. In addition, the consultant pharmacist failed to identify the need for a dosage reduction and/or continued need for the use of an antidepressant, and failed to identify the lack of monitoring for efficacy of an antidepressant used for insomnia for 2 of 5 residents (R10, R1) reviewed for unnecessary medications. Findings include: R6's quarterly Minimum Data Set (MDS) dated 9/3/14, also indicated R6 had intact cognition, required extensive staff assistance with all activities of daily living and was unable to ambulate. The MDS indicated R6 had diagnosis including cerebral palsy, anxiety, diabetes mellitus and congestive heart failure. The MDS also indicated R6 suffered from frequent pain which prevented her from participating in daily activities. During the assessment period, R6 had reported her pain to be at a 6 on a 0-10 (10 is worst) pain scale. R6's care plan dated 6/4/14, identified an alteration in comfort related to numbness/tingling in the hands secondary to carpal tunnel syndrome and muscle spasticity secondary to cerebral palsy. The plan directed staff to anticipate her needs and respond in a timely manner. The care plan did not direct staff on how to minimize potential leg pain and it did not include non-pharmacological interventions to minimize R6's pain. The Physician Order Report dated 9/5/14,	21530	Element 1 The consulting Pharmacist has reviewed the medication irregularities related to PRN pain medications for residents R6, R11, who had chronic pain. Changes have been made as recommended. The consulting pharmacist reviewed R14 and R1□s routing medication irregularities and made recommendations as appropriate. Element 2 The consulting pharmacist has reviewed all resident charts for PRN and routine medication irregularities and made appropriate recommendations. Element 3 The policy and contract regarding consulting pharmacy services and medication review was reviewed with the consulting pharmacist. The consulting pharmacist has access to the EMR for efficiency of pharmacy review. Element 4 The DON/Designee will audit the consulting pharmacist report monthly ongoing. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly. □	

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included Baclofen (muscle relaxer) 10 mg three times a day, Gabapentin (medication used to treat nerve pain) 300 milligrams (mg) three times a day, Tylenol extra strength 500 mg one tablet every four hours as needed (PRN) for pain, and Fentanyl (narcotic pain patch) 25 micrograms (mcg)/ hour to be changed every three days.

On 10/1/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry with tears running down her face calling out to staff. She stated, "Oh, oh oh."

On 10/2/14, at 9:00 a.m. R6 was observed seated in a wheelchair in the dining room. R6 began to cry, "Ey, ey, ey, oh that leg." R6 turned her head looking for staff members and began to cry "oh my goodness" as she shook her head.

At 9:10 a.m. nursing assistant (NA)-A stated R6 cried out in pain every day. She stated R6 would complain while sitting in her wheelchair. NA-A reported R6 received pain medications for pain management but she often has to wait until it is time for the next medication. She stated R6 frequently watched the clock in her room waiting for the next pain medication.

On 10/2/14, at 9:45 a.m. R6 stated she experienced pain in her left leg every day and will ask for Tylenol. She explained the Tylenol takes care of the pain for about an hour. R6 explained the pain in her left leg woke her at night and she often had to watch the clock to wait for her next dose of pain medication. R6 described the pain at an 8 or 9 on a 0-10 pain scale daily. R6 stated she has to watch the clock to make sure she is receiving her pain medications.

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21530	Continued From page 55 Review of the electronic medication administration record (EMAR) revealed the following information about excessive use of as needed Tylenol: 7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol. 7/1/14 - 7/31/14, R6 had received 90 doses of PRN Tylenol. 8/1/14 - 8/31/13, R6 received 81 doses of PRN Tylenol 500 mg. 9/1//14 - 9/30/14, R6 received 98 doses of PRN Tylenol 500 mg. 10/1/14- 10/2/14, R6 had received 6 doses of PRN Tylenol 500 mg. On 10/2/14, at 10:10 a.m. licensed practical nurse (LPN)-B stated R6 reported complaints of pain "all of the time." She stated R6 will request pain medications and will watch the clock waiting for the four hours to pass before she can ask for the next pill. LPN-B stated R6 was uncomfortable, "I wish we could find something to give her relief." On 10/2/14, at 11:00 a.m. R6's pain was reviewed with the interim director of nursing (DON) and the consultant registered nurse (RN). The interim DON stated she was aware R6 expressed pain daily. The two RNs reviewed R6's clinical record and were unable to find indication in which the staff had completed a comprehensive assessment of R6's pain and were unable to determine if the Fentanyl which had been added in 7/2014, was an effective medication for controlling the pain.	21530		

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21530	Continued From page 56 On 10/2/14, at 11:20 a.m. the consultant RN confirmed R6 experienced pain daily and had not been comprehensively reassessed by the nurses to determine the extent of the pain. She stated she was aware R6 was utilizing PRN medications for the treatment of pain but was not aware she was utilizing over 70 PRN medications per month. Review of the monthly consultant pharmacist medication regimen reviews indicated the reviews had been completed without any type of concerns identified by the pharmacist. On 10/2/14, at 4:00 p.m. the consultant pharmacist stated she started visiting the facility one month ago. She stated at the time of the consult, she did not have access to the electronic medical records or EMARs. She confirmed she had not reviewed R6's PRN medication usage as she did not have access at the time of the review. She stated if she would have noted that a resident was utilizing over 80 PRN doses of pain medications each month, she would have pointed this out to the attending physician. A policy related to medication reviews was requested and none was provided. R11's Physician Order Report dated 9/3/14-10/3/14, indicated R11 had diagnoses that included osteoporosis (a disease in which bones become fragile and more likely to fracture), lower leg osteoarthritis (degenerative arthritis affecting the cartilage), chronic pain, and Wegener's granulomatosis (causes inflammation of the blood vessels). R11's significant change MDS dated 8/11/14, indicated R11 had severe cognitive impairment and required extensive assistance of one staff for	21530		

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locomotion on and off the unit, dressing and personal hygiene and limited assistance of one staff for bed mobility, transfer, ambulating in room and corridor and toilet use. The MDS also indicated R11 received scheduled and as needed pain medication and non-medication interventions for pain. The MDS also indicated R11 reported her pain as moderate and frequent but it did not interfere with daily activities or make it difficult to sleep at night. The MDS further indicated R11 received physical therapy (PT) and occupational therapy (OT) services and received active range of motion (ROM) restorative nursing services.

R11's care plan dated 7/17/14, identified R11 had alteration in comfort related to pain secondary to history of compression fractures of her back and indicated R11 would verbally state pain was 2-3 on a verbal scale of 0-10 after administration of pain medication. The care plan directed staff to administer medications as ordered for pain and to monitor for effectiveness of pain medications and possible side effects.

The Nursing Home Note dated 7/29/14, indicated R11 was seen regarding family concerns related to pain, delirium, hearing and intake issues. The physician's impression included pain issues with vertebral compression fractures and arthritis. The physician's plan was to not change medications until R11's shortness of breath (identified upon physician examination) was evaluated.

R11 was hospitalized from 7/31/14 through 8/4/14, for pneumonia.

The facility completed Pain Data Collection for R11 on 8/5/14 - 8/9/14. The RN assessment summary of the data collection completed on

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21530	Continued From page 58 8/13/14, identified R11 had complained of pain during the assessment period. The Physician Order Report dated 9/3/14-10/3/14, included orders for Lidoderm adhesive patch (a local anesthetic) 5% (700 milligrams (mg)/patch) apply 1 new patch topically to mid-back daily on 12 hours and off 12 hours for chronic pain, Norco (narcotic pain reliever for moderate to severe pain) 5-325 mg three times a day (scheduled dose), Norco (hydrocodone-acetaminophen) 5-325 mg 1 tab twice a day PRN for pain, and acetaminophen 500 mg 1 tab every 6 hours PRN for pain. R11's Medication Administration History dated 8/8/14 -10/3/14 revealed: -Lidoderm adhesive patch 5% was administered early at R11's request 30 of 57 days. -Norco 5-325 mg three times a day (scheduled dose) was given early for the morning dose on 8/25, 9/12, 9/22, 9/25, 9/26, 9/29, 9/30, 10/1, 10/2, and 10/3 and for the afternoon dose on 9/9 (11 doses). R11's PRN Medications Administration History 8/8/14-10/3/14 revealed: -Norco 5-325 mg 1 tab twice a day PRN, 32 doses were given on 29 of 57 days for complaints of pain in knees or legs. -acetaminophen 500 mg 1 tab every 6 hours as needed was given once on 8/8, 8/30, and 9/3 and given three times on 10/2 for complaints of pain in knees or legs. On 10/2/14, at 9:04 a.m. R11 was observed seated in her room seated in a recliner. R11 stated she had been having a lot of problems with	21530		

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her right knee and raised her pant leg above her knee and began to rub it. The knee was observed to be swollen. R11 stated she was given pain pills for the knee pain and that they lasted a little while "but they don't last forever." She stated that on 10/1/14, she was given cold packs, as well, and that helped for a little bit. R11 stated the pain keeps her up at night at times and that the previous night she was "up a lot" until she finally got a pain pill. R11 stated the pain medication lasted for about 4 hours before her knee began hurting again. R11 also stated she asks for a pain pill a couple of times a day and identified her pain at that time at an 8 out of 10.

On 10/2/14, at 10:43 a.m. R11 was observed seated in her room in a recliner with a wheeled walker in front of her chair. R11 stated the pain limited her activities during the day and prevented her from joining in. She stated, "I just can't do it." R11 stated her knee currently still ached and was a 7 out of 10 on a 1 to 10 pain scale. R11 stated her knee hurt all the time but it was alright if she sat "absolutely still." R11 further indicated walking made her knee feel worse.

On 10/02/2014, at 2:39 p.m. LPN-B stated R11 received scheduled pain medication three times a day and could also have PRN pain medication for her knee pain. She stated if R11 asked for extra pain medication, it was usually needed on the night shift but was occasionally given during the day. LPN-B stated PRN Norco was usually given.

Review of the monthly consultant pharmacist medication regimen reviews indicated the reviews had been completed without any concerns regarding pain management identified by the pharmacist.

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21530	Continued From page 60 On 10/2/14, at 3:45 p.m. the consultant pharmacist stated she started visiting the facility one month ago. She stated at the time of the consult, she did not have access to the electronic medical records or EMARs. She confirmed she had not reviewed R11's pain medication usage as she did not have access at the time of the review. A policy related to medication reviews was requested and none was provided. R10's Physician Order Report dated 9/3/14, directed Paxil (an antidepressant medication) 10 mg daily for the treatment of depression. The medication was started on 7/3/2013. The clinical record lacked documentation of an attempted dose reduction since start date of 7/13. In addition, the record lacked documentation why a reduction would be contraindicated for R10. R10's quarterly MDS dated 9/5/14, and the annual MDS dated 7/1014, identified R10 as being alert and oriented with no mood or behavior concerns. The assessment indicated R10 received antidepressant medications daily. The Psychotropic Medication Use Care Area Assessment dated 7/10/14, indicated R10 participated in activities and did not not show signs of depression. The care plan dated 7/15/14, identified R10 as receiving antidepressant medication for the treatment of major depression and sleeplessness. The care plan directed the staff to encourage the resident to stay up after meals and to participate in activities in the facility.	21530		

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21530	Continued From page 61 On 10/1/14, at 12:20 p.m. RN-A stated R10 will occasional sleep when he is depressed. She stated R10 does not show any other symptoms of depression. The Consultant Pharmacist Medication Review completed on 12/10/13, read: "CMS (Center for Medicare/Medicaid services) regulations required two gradual dose reductions or assessment the first year for all psychopharmacological medication to determine the continued need for the order." "Consider a reduction or, if you feel any reduction would put resident in undue psychiatric distress, please list the risk and benefits for this dose." The physician responded, "He is on the lowest dose and tolerated well and his depression is good continue med." The note did not address why reduction would be contraindicated. On 10/1/14, at 1:30 p.m. RN-B stated confirmed the consultant pharmacist brought the concern of antidepressant medication reduction to the attention of the physician in 12/13, but confirmed the medication has not been addressed since that time. RN-B stated R10 occasionally naps but does not show any other symptoms of depression. On 10/2/14, at 4:00 p.m. the consultant pharmacist stated she started visiting the facility one month ago. She stated at the time of the consult, she did not have access to the electronic medical records or EMARs. She stated she had noticed R10 was receiving Paxil but did not feel she should make any type of recommendations until she could review the clinical record and get to know the resident a bit more. The pharmacist confirmed residents receiving antidepressants were to receive two attempted dose reductions	21530		

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21530	Continued From page 62 during the first year. R1's Resident Admission Record dated 10/2/14, indicated diagnoses that included chronic pain, dysthmic disorder (a chronic type of depression), thoracic spondylosis (degenerative osteoarthritis of the joints between the center of the spinal vertebrae) and insomnia. The current physician's orders printed 10/2/14, directed nortriptyline (an antidepressant) 50 at bedtime. R1's quarterly MDS dated 7/10/14, indicated R1 was cognitively intact. The MDS also indicated R1 had poor appetite or overeating 2-6 days, felt bad about himself 2-6 days, and received antidepressant medication daily R1's care plan dated 7/16/14, indicated R1 received nortriptyline for sleep and identified a goal for R1 to receive the lowest dose of medication to alleviate signs and symptoms of insomnia. The care plan directed staff to monitor for signs and symptoms of depression, anxiety and insomnia. The Consultant Pharmacist's Medication Regimen Review Report dated 7/25/12, identified nortriptyline was started October 2011 and was prescribed for chronic pain and neuropathies, along with insomnia and depression. Review of the monthly consultant pharmacist medication reviews indicated the reviews had been completed without any concerns regarding nortriptyline use identified by the pharmacist. R1's medical record indicated the most recent sleep monitoring assessment was dated December 2013.	21530		

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21530	Continued From page 63 On 10/01/2014, at 1:10 p.m. RN-A stated the facility's side effect monitoring process had just been reorganized and they were planning to start on 10/1/14. RN-A confirmed no sleep monitoring had been done for R1 since December 2013. RN-A stated the facility had lost some staff last year and this had been missed. On 10/02/2014, at 8:38 a.m. interim DON confirmed sleep monitoring had not been completed since December 2013, and should have been, as directed by the care plan. DON confirmed she would have expected the pharmacist to have identified the lack of sleep monitoring for the medication. On 10/2/14, at 3:49 p.m. the consultant pharmacist stated she only made one visit to the facility and had not had a chance to get to know the residents and their history. She stated the physician may have changed the indication for R1's nortriptyline use to address his neurogenic pain rather than for sleep and then may have suspended sleep monitoring. A policy regarding sleep monitoring was requested but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee and the consulting pharmacist could establish a system to monitor residents recieving antipsychotic medications and assure adequate indications for use are identified. The quality assurance committee could review the process to ensure continued compliance.	21530		

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21530	Continued From page 64 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to attempt a dosage reduction for the use of an antidepressant, and failed to monitor efficacy of an antidepressant used for insomnia for continued need, for 2 of 5 residents (R10, R1) reviewed for unnecessary medications.	21540	Element 1 Residents R14□s and R1□s medications were reviewed for clinical indications, gradual dose reductions (GDR) were made when the clinical indications reveal the benefit outweighs the risk to decrease and the rationale is documented in the	11/12/14

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HOMESTEAD REHABILITATION & LIVING CEN	115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 65 Findings include: R10's Physician Order Report dated 9/3/14, directed Paxil (an antidepressant medication) 10 milligrams (mg) daily for the treatment of depression. The medication was started on 7/3/2013. The clinical record lacked documentation of an attempted dose reduction since start date of 7/13. In addition, the record lacked documentation why a reduction would be contraindicated for R10. R10's quarterly Minimum Data Set (MDS) dated 9/5/14, and the annual MDS dated 7/1014, identified R10 as being alert and oriented with no mood or behavior concerns. The assessment indicated R10 received antidepressant medications daily. The Psychotropic Medication Use Care Area Assessment dated 7/10/14, indicated R10 participated in activities and did not not show signs of depression. The care plan dated 7/15/14, identified R10 as receiving antidepressant medication for the treatment of major depression and sleeplessness. The care plan directed the staff to encourage the resident to stay up after meals and to participate in activities in the facility. During the survey conducted on 9/29/14, from 4:00 p.m. to 8:00 p.m., on 9/30/14, from 8:00 a.m. to 4:30 p.m., on 10/1/14, from 7:00 a.m. to 3:30 p.m., on 10/2/14, from 8:00 a.m. to 4:30 p.m., and on 10/3/14, from 8:00 a.m. to 12:00 p.m., R10 was observed to participate in activities of choice, wheel himself around the facility, and interacted with other residents, staff and visitors. R10 was	21540	patient chart. Element 2 All residents who take psychotropic medications were assessed for indications for use, appropriateness of gradual dose reduction and documented rationale. Element 3 The policy was reviewed and updated as appropriate. New admission medications will be reviewed for appropriate indications for use. The consulting pharmacist will audit all resident□s medication regimens monthly. SW/RN will monitor all psychotropic medications for gradual dose reductions and documented benefit vs risk rationale at least quarterly. SW, consulting pharmacist and RNs were educated regarding the protocol for gradual dose reduction. Element 4 The consulting pharmacist will audit each resident□s medication regime monthly. SW/RN will review each resident medication regimen at least quarterly. The DON/designee will monitor psychotropic medications for GDR or documentation of rationale explaining the benefit vs risk weekly x 4 weeks, then monthly x 2 months and thereafter quarterly. Variances will be reported to the Administrator for immediate follow up and reviewed at QAPI at least quarterly.	

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21540	Continued From page 66 not observed to display symptoms of depression. On 10/1/14, at 12:20 p.m. registered nurse (RN)-A stated R10 will occasional sleep when he is depressed. She stated R10 does not show any other symptoms of depression. The Consultant Pharmacist Medication Review completed on 12/10/13, read: "CMS (Center for Medicare/Medicaid services) regulations required two gradual dose reductions or assessment the first year for all psychopharmacological medication to determine the continued need for the order." "Consider a reduction or, if you feel any reduction would put resident in undue psychiatric distress, please list the risk and benefits for this dose." The physician responded, "He is on the lowest dose and tolerated well and his depression is good continue med." The note did not address why reduction would be contraindicated. On 10/1/14, at 1:30 p.m. RN-B stated confirmed the consultant pharmacist brought the concern of antidepressant medication reduction to the attention of the physician in 12/13, but confirmed the medication has not been addressed since that time. RN-B stated R10 occasionally naps but does not show any other symptoms of depression. R1's Resident Admission Record dated 10/2/14, indicated diagnoses that included chronic pain, dysthmic disorder (a chronic type of depression), thoracic spondylosis (degenerative osteoarthritis of the joints between the center of the spinal vertebrae) and insomnia. The current physician's orders printed 10/2/14, directed nortriptyline (an antidepressant) 50 at bedtime.	21540		

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21540	Continued From page 67 R1's quarterly MDS dated 7/10/14, indicated R1 was cognitively intact. The MDS also indicated R1 had poor appetite or overeating 2-6 days, felt bad about himself 2-6 days, and received antidepressant medication daily The Psychotropic Medication Use CAA dated 1/10/14, indicated R1 was alert and oriented, and aware of reasons for medication use. He went willingly to psych visits and was able to self report new symptoms. The CAA also indicated a potential for unwanted side effects from the use of 2 different antidepressant medications. R1's care plan dated 7/16/14, indicated R1 received nortriptyline for sleep and identified a goal for R1 to receive the lowest dose of medication to alleviate signs and symptoms of insomnia. The care plan directed staff to monitor for signs and symptoms of depression, anxiety and insomnia. The Consultant Pharmacist's Medication Regimen Review Report dated 7/25/12, identified nortriptyline was started October 2011 and was prescribed for chronic pain and neuropathies, along with insomnia and depression. R1's medical record indicated the most recent sleep monitoring assessment was dated December 2013. On 09/30/2014, at 2:14 p.m. R1 was observed participating in a bean bag toss activity in the lounge area. R1 was observed to be engaged and participating in the activity. His affect was full and R1 was smiling. On 10/01/2014, at 1:10 p.m. RN-A stated the	21540		

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21540	Continued From page 68 facility's side effect monitoring process had just been reorganized and they were planning to start on 10/1/14. RN-A confirmed no sleep monitoring had been done for R1 since December 2013. RN-A stated the facility had lost some staff last year and this had been missed. On 10/02/2014, at 8:38 a.m. interim director of nursing (DON) confirmed sleep monitoring had not been completed since December 2013, and should have been, as directed by the care plan. DON confirmed she would have expected the pharmacist to have identified the lack of sleep monitoring for the medication. On 10/02/2014, at 9:18:a.m. R1 stated he slept well. R1 stated he is able to fall asleep and stay asleep throughout the night. R1 also stated if he does wake during the night, he is able to return to sleep without difficulty. R1 further stated he was happy with his medication regimen at this time and had no difficulties. A policy regarding sleep monitoring was requested but none was provided. SUGGESTED METHOD OF CORRECTION: The Direcor of Nursing could review and revise policies and procedures for care delivery systems and provide staff training for monitoring of medications. A designated staff could monitor the system to assure the monitoring is provided for residents recieving antipsychotic, antianxiety and anti depressent medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		

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21695	Continued From page 69	21695		
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, interview, and document review, the facility failed to maintain resident rooms and common areas clean and in good repair for 8 of 8 resident rooms (#121, 126, 132, 101, 102, 103, 104 and 105) and throughout the dining area and facility corridors. Findings include: On 10/1/14, at 11:45 a.m. a tour of the facility was completed with the maintenance director (MD). -The south wall of the dining room had black scuff marks approximately 4 feet by a 1 foot area. -The long wall of the dining room was 22 feet long and had a chair railing. Approximately 4 inches down from the chair railing were numerous black scuff areas on the wall. -The East wall of the dining room was 5 feet long with a chair railing. Approximately 4 inches down from the chair railing were numerous black scuff areas on the wall. -The West wall of the dining room was 7 feet by 33 inches with various black scuff marks. -The back North dining room wall was 3 feet by 1 foot, and the East wall was 14 inches by 10 inches. Both walls have numerous black scuff marks.	21695	Element 1 Resident rooms (121, 126, 132, 101, 102, 103, 104, 105), bathrooms, and common areas as identified during the survey have been maintained, cleansed and painted. Element 2 An audit of resident rooms, bathrooms, and common areas was performed for identification of other areas in need of maintenance, cleansing or painting. Element 3 A mechanism is in place for maintenance notification of resident rooms, bathrooms, and common areas in need of maintenance, cleansing or painting. All staff has been educated on identify, reporting, and obligation to provide clean and sanitary conditions. There is schedule for maintenance to observe resident rooms, bathrooms, and common areas in need of maintenance, cleansing, paint. Element 4 The Administrator/Designee will audit maintenance observation schedule and	11/12/14

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21695	Continued From page 70 The MD stated the dining room walls were made of plastic. The MD stated the black scuff marks could be removed by the housekeeping staff with a magic eraser. The MD stated they had also used a special coating paint for the plastic in the past. -The East wall corridor outside the porch area, was 8 feet by 10 inches with numerous black scuff marks. -The West wall outside the porch area, was 12 feet by 15 inches with numerous black scuff marks. -The West corridor outside the living room was 14 feet by 12 inches with numerous black scuff marks. -The East wall outside the living room was 8 feet by 12 inches with numerous black scuff marks. -The walls by the resident/staff restroom were 30 inches by 3 feet, and 6 feet by 40 inches with black scuff marks. -The West wall of the sun room was 8 feet by 30 inches. The South wall was 11 feet by 2 feet, and the East wall was 7 feet by 12 inches long with numerous black scuff marks. -In room 121 there were several gouges in the wooden door to the room. -In room 126 there was sheetrock and paint missing from the walls. -In room 132 there were several gouges in the wooden door to the room. -In room 101 the walls had black scuff marks. In addition, there was duct tape on the door face over the chipped wood. There were several gouges in the wooden door to the room.	21695	repair work weekly x 4 weeks, then monthly x 2 months and quarterly ongoing. Variances will be reviewed at QAPI at least quarterly. □	

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21695	Continued From page 71 -In room 102 there was paint missing above the bed. The South wall was 80 inches by 3 feet with numerous black scuff marks -In room 103 there were several gouges in the wooden door to the room. -In room 104 the West wall was 3 feet by 12 inches and the South wall was 4 feet by 1 foot with numerous black scuff marks. -In room 105 the bathroom register had an area 45 inches by 7 inches scraped down to the bare metal. The East wall was 41 inches by 13 inches with black scuff marks. -The entire East hallway 100 feet long had numerous black scuff marks on the lower level of the plastic walls. -The North hallway 74 feet long had numerous black scuff marks on the lower level of the plastic walls. The MD stated the black scuff marks were from wheelchairs and mechanical lifts hitting the walls. The MD stated the housekeeping staff did the wall cleaning and the maintenance staff would do the repairs and the painting. On 10/1/14, at 12:42 p.m. maintenance staff (MS)-A stated an annual building inspection was scheduled for September 2014, and had not been completed. On 10/2/14, at 8:40 a.m. the nutrition services manager (NSM) stated she took over the role of monitoring the housekeepers in April 2014. The NSM stated there had been turnover with the housekeepers, and they were short in the housekeeping department and there were two positions open.	21695		

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21695	Continued From page 72 At 9:30 a.m. the NSM stated they do extra cleaning during an eight week period in the spring. The NSM stated there was no documentation the cleaning was done. The routine housekeeping policy dated 1/91, indicated the facility would be maintained in a clean, sanitary, and orderly condition. During the extra cleaning which covered an eight week period all the walls in hallways, resident rooms and bathrooms would be washed. SUGGESTED METHOD OF CORRECTION: The director of facility operations or his designee could develop a system to ensure the environment was clean, comfortable and checked on a routine basis. The director of facility operations or his designee could develop a system for staff to report any concerns with the physical plant. All facility staff could be educated on these systems. The director of facility operations or his designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Twenty one (21) days.	21695		