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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5PIE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00629

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245325**

2.STATE VENDOR OR MEDICAID NO.
(L2) **781843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLEY NURSING CENTER**
(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

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 **06/23/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Kathy Lucas, Unit Supervisor — 06/23/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/01/2017 (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
07/01/1986
(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 08/08/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/30/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245325 July 5, 2017

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

Dear Mr. Huhta:

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 June 16, 2017 the above facility is recommended for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 5, 2017

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

RE: Project Number S5325026

Dear Mr. Huhta:

On May 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 27, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 23, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 27, 2017, effective June 16, 2017 and therefore remedies outlined in our letter to you dated May 10, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 5, 2017

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

RE: Project Number S5325026

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On June 12, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 23, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 27, 2017, effective June 16, 2017 and therefore remedies outlined in our letter to you dated May 10, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

July 6, 2017

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

Re: Reinspection Results - Project Number S53252026

Dear Mr. Huhta:

On June 23, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 27, 2017, with orders received by you on May 17, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5PIE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00629

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245325**

2.STATE VENDOR OR MEDICAID NO.
(L2) **781843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLEY NURSING CENTER**
(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

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 **04/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Annette Truebenbach, HFE NE II 05/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/27/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(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 06/30/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 10, 2017

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

RE: Project Number S5325026 and F5325026

Dear Mr. Huhta:

On April 27, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathy Lucas, Unit Supervisor
St. Cloud B Survey Team
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
kathy.lucas.state.mn.us
Telephone: (320)223-7343 Fax: (320)223-7348

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 June 6, 2017, 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 June 6, 2017 the following remedy will be imposed:

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

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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 July 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	**253 PINE STREET FOLEY, MN 56329**

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to provide timely repositioning for 1 of 3 residents (R112), and failed to provide oral care for 1 of 3 residents (R9) reviewed for following the care plan. Findings include: R112's admission Minimum Data Set (MDS) indicated R112 required extensive assist of two with transfers and bed mobility, was at risk for developing pressure ulcers and had severe cognitive impairment.	F 282	Care plans for R112 & R9 have been reviewed and updated as needed to reflect current status. All residents who are dependent on staff for ADL assist and repositioning have had their care plans reviewed and/or updated as needed. The policy and protocols on repositioning and oral cares was reviewed and is current.	6/6/17

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

Electronically Signed | 05/19/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	**253 PINE STREET FOLEY, MN 56329**

(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 282	Continued From page 1 R112's care plan revised on 12/30/16, indicated R112 had a deficit in self care related to dementia, confusion, impaired balance, impaired mobility, weakness and required assistance with toileting and repositioning every 2 hours and as needed. During continuous observation on 4/26/17, starting at 6:45 a.m. R112 was sitting in her wheelchair in the common area between the 300 and 400 units, close to the nurses station. At 7:45 a.m. R112 was pushed in her wheelchair to the beauty shop, where she remained in her wheelchair. At 8:20 a.m. nursing staff pushed her to the dining room for breakfast. Following breakfast, nursing staff returned R112 back to the commons area still sitting in her wheelchair. At 10:07 a.m. Nursing assistant (NA)-F brought R112 into the tub room in the 400 hall. NA-F asked another NA to assist her in toileting R112. Licensed practical nurse (LPN)-D entered the tub room with R112 along with the 2 NAs and toileting/repositioning was provided. During interview on 4/26/17, at 10:21 a.m. NA--F stated R112 was last toileted and repositioned at approximately 6:30 a.m. when they got her up in the morning and they were not able to get to her again until after 10:00 a.m. (3.5 hours). NA-F stated the reason they were later in getting to her today was that the other NA got pulled to the memory care unit. NA-F stated normally they would have toileted R112 by 9:00 am, right after breakfast and would have repositioned R112 every 2 hours, but since the other NA was pulled away today, she (NA-F) was doing the best she could. NA-F further stated that R112's care plan indicated R112 should be repositioned every 2	F 282	Care Managers will initially audit all care plans to assure appropriate interventions are in place for oral hygiene and needed repositioning assistance. Thereafter, Care Managers will conduct daily audits of ADL□s and repositioning timeliness through PCC documentation. Additionally, Care Managers will conduct observational audits of 10% of those residents identified with oral & repositioning needs to assure compliance with documentation & care plan interventions daily for 7 days. Thereafter, these audits will continue 2X weekly for 2 weeks & then 1X/week on varied days for 30 days or until 100% compliance is achieved. Individual audits will be conducted on an ongoing basis at the time of the residents MDS observational period. All staff providing personal care to residents shall be educated on the need to complete care plan interventions as directed on 5/22/2017 and 5/23/2017. A repositioning and oral cares tracking/audit tool will be used for monitoring. DON or designee shall compile audit data. Results of monitoring activities will be submitted monthly to the QA Committee for review and recommendations.	

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F 282	Continued From page 2 hours due to her risk for skin breakdown. During interview on 4/26/17, at 11:29 a.m. LPN-D stated R112 was toileted and repositioned later then normal. LPN-D further stated that per the care plan, R112 should be repositioned every 2 hours, however, that morning it was not done in accordance with the care plan. LPN-D stated R112 could be at risk for skin breakdown when she is not repositioned at least every 2 hours. During interview on 4/26/17, at 12:57 p.m. the director of nursing (DON) stated it was "not good" that R112 did not get repositioned. The DON stated R112 was at risk due to possible moisture and skin breakdown. The DON stated R112 depended on them for repositioning and it was her expectation that the NA's either walkie another NA or herself to assist when they are not able to complete cares and hoped they were communicating with each other when they can not get to someone. Facility policy Comprehensive Care Plan revision date of 11/16/16, indicated the purpose of the policy, "Is to develop and implement a comprehensive care plan that is person centered for each resident and consistent with resident rights, to ensure we provide the necessary care and services to attain or maintain the highest possible physical, mental and psychosocial well being, consistent with the resident's comprehensive assessment." R9's annual MDS dated 11/15/16, identified a moderate cognitive impairment, needed extensive assistance with personal hygiene including brushing her teeth, and was edentulous (had no teeth).	F 282		

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F 282	Continued From page 3	F 282		

R9's current care plan dated 2/14/17, identified an ADL (activities of daily living) self-care deficit due to muscle weakness and pain, indicating she needed extensive assistance from one staff with personal hygiene, but could complete oral cares independently once set up. The care plan identified R9 had upper dentures and directed oral cares were suppose to be done in the morning and evening, identified, "[R9] is able to rinse dentures and rinse mouth with mouthwash independently after setup."

R9's Bedside Kardex report, dated 4/27/17, again identified she wore upper dentures, oral care was provided morning and evenings, and could complete oral care independently after setup.

During interview on 4/24/17, at 6:40 p.m. R9 stated she did not receive any assistance with oral cares and did not have any dentures. During interview, R9 was observed without teeth or dentures in her mouth.

During observation on 4/26/17, at 7:18 a.m. R9's morning cares were being finished. NA-D and NA-E were observed to transfer R9 from her bed to the wheelchair using a PAL lift (mechanical lift to help sit to stand). R9 was already dressed and once in the wheelchair, NA-E asked if R9 needed to use the restroom. R9 was brought out of her room into a larger bathroom. After toileting, R9 was brought back into her room, NA-E left the room, and NA-D made R9's bed. R9 asked for her lipstick and after giving R9 her lipstick, NA-D proceeded to ask R9's roommate (R28) if she wanted to complete oral cares. NA-D left the room and returned with two new toothbrushes, one for R9 and one for R28. NA-D assisted R28 with her oral cares, then asked R9 if she wanted

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F 282	Continued From page 4	F 282		

to brush her teeth before or after breakfast. R9 responded she wanted to brush after breakfast.

During continuous observation on 4/26/17, at 8:37 a.m. R9 was just finishing breakfast in the dining room. A couple of minutes later at 8:39 a.m. an unidentified staff member took R9 from the dining room back to her room. No oral cares were provided. At 9:12 a.m. R9 continued to sit in her room, listening to music on a radio. At 9:40 a.m. R9 was observed in her room and did not have dentures in her mouth. And at 9:59 a.m. R9 continued to be in her room. No oral cares were provided after breakfast.

During interview on 4/26/17, at 10:34 a.m. NA-D stated staff would get R9 dressed, and R9 would finish up brushing her hair, applying her make up, and brushing her teeth. NA-D stated R9 did her own oral care around 9:00 a.m. that morning after breakfast, however, when NA-D observed R9's bathroom during the interview, R9's new toothbrush had not been touched, was still sealed in the original wrapper, and was out of reach in a basin sitting on top of a metal shelf above the sink. NA-D reported she had just brought in the new toothbrush that morning for R9 to use, but had not gone back to set up the toothbrush, or check with R9 to see if oral cares had in fact been completed. NA-D searched for R9's dentures in white plastic standing drawers to the left of the sink, reporting the dentures should have been in there, and R9 rinses them herself. NA-D went over to R9 who stated she didn't have dentures.

During interview on 4/26/17, at 11:31 a.m. NA-E stated R9 wore dentures only when she wanted to and was constantly moving the dentures

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F 282	Continued From page 5 around in her room. NA-E stated staff would set R9 up for her oral cares, then R9 would brush some, and staff would assist R9 to finish if she needed help. NA-E thought R9's oral cares had been competed shortly after R9 got up that morning, stating her partner, NA-D, had set R9 up for oral cares. NA-E was not aware NA-D had not completed oral cares either. During interview on 4/26/17, at 1:13 p.m. registered nurse (RN)-B stated R9 only needed set up assistance and supervision with oral cares. RN-A stated she would have expected the nursing assistants to go back, made sure R9 completed oral cares, and provided assistance with brushing if she needed it. RN-B reported R9's oral cares were suppose to be done every morning and evening with cares. During interview on 4/27/17, at 1:59 p.m. the DON stated residents with dentures or teeth should have as much assistance as they needed to complete oral care. The DON further stated oral cares were to be provided in the morning and evening at a minimum. A facility policy entitled Teeth, Brushing, revised 10/19/16, directed, "A resident should be assisted with brushing his or her teeth based on his or her individual needs."	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		6/6/17

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F 312	Continued From page 6 by: Based on observation, interview and document review, the facility failed to ensure residents were provided assistance with oral cares for 1 of 3 residents (R9) reviewed for activities of daily living (ADLs). Findings include: R9's annual Minimum Data Set (MDS) dated 11/15/16, identified a moderate cognitive impairment, needed extensive assistance with personal hygiene including brushing her teeth, and was edentulous (had no teeth). R9's MDS Dental Assessment, dated 2/14/17, indicated she had upper dentures, which R9 reported were loose, but declined a dental appointment. R9's assessment identified no oral concerns, and directed, "Staff assist in denture cares. [R9] is able to complete the rest of her oral cares independently after setup." R9's current care plan dated 2/14/17, identified an ADL self-care deficit due to muscle weakness and pain, indicating she needed extensive assistance from one staff with personal hygiene, but could complete oral cares independently once set up. The care plan identified R9 had upper dentures and directed oral cares were suppose to be done in the morning and evening, and identified "[R9] is able to rinse dentures and rinse mouth with mouthwash independently after setup." R9's Bedside Kardex report dated 4/27/17, identified she wore upper dentures, oral care was provided morning and evenings, and could complete oral care independently after setup.	F 312	R9□s care plan & care sheets have been reviewed and are current. All residents who are dependent on staff for ADL assistance with oral cares have had their care plans reviewed and/or updated as needed. The policy and protocols on oral cares was reviewed and is current. Care Managers will initially audit all care plans to assure appropriate interventions are in place for oral hygiene assistance. Thereafter, Care Managers will conduct daily audits of ADL□s , focusing on oral hygiene timeliness through PCC documentation. Additionally, Care Managers will conduct observational audits of 10% of those residents identified with oral needs to assure compliance with documentation & care plan interventions daily for 7 days. Thereafter, these audits will continue 2X weekly for 2 weeks & then 1X/week on varied days for 30 days or until 100% compliance s achieved. Individual audits will be conducted on an ongoing basis at the time of the residents MDS observational period. All staff providing personal care to residents shall be educated on the need to complete care plan interventions as directed by 5/22/2017 and 5/23/2017. An oral cares tracking/audit tool will be used for monitoring. DON or designee shall compile audit data. Results of monitoring activities will be submitted monthly to the QA Committee for review and recommendations.	

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F 312	Continued From page 7 During interview on 4/24/17, at 6:40 p.m. R9 stated she did not receive any assistance with oral cares and did not have any dentures. During interview, R9 was observed without teeth or dentures in her mouth. During observation on 4/26/17, at 7:18 a.m. R9's morning cares were being finished. Nursing assistant (NA)-D and NA-E were observed to transfer R9 from her bed to the wheelchair using a PAL lift (mechanical lift to help sit to stand). R9 was already dressed and once in the wheelchair, NA-E asked if R9 needed to use the restroom. R9 was brought out of her room into a larger bathroom. After toileting, R9 was brought back into her room, NA-E left the room, and NA-D made R9's bed. R9 asked for her lipstick and after giving R9 her lipstick, NA-D proceeded to ask R9's roommate (R28) if she wanted to complete oral cares. NA-D left the room and returned with two new toothbrushes, one for R9 and one for R28. NA-D assisted R28 with her oral cares, then asked R9 if she wanted to brush her teeth before or after breakfast. R9 responded she wanted to brush after breakfast. During continuous observation on 4/26/17, at 8:37 a.m. R9 was just finishing breakfast in the dining room. A couple of minutes later at 8:39 a.m. an unidentified staff member took R9 from the dining room back to her room. No oral cares were provided. At 9:12 a.m. R9 continued to sit in her room, listening to music on a radio. At 9:40 a.m. R9 was observed in her room and did not have dentures in her mouth. And at 9:59 a.m. R9 continued to be in her room. No oral cares were provided after breakfast.	F 312	.	

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During interview on 4/26/17, at 10:34 a.m. NA-D stated staff would get R9 dressed, and R9 would finish up brushing her hair, applying her make up, and brushing her teeth. NA-D stated R9 did her own oral care around 9:00 a.m. that morning after breakfast, however, when NA-D observed R9's bathroom during the interview, R9's new toothbrush had not been touched, was still sealed in the original wrapper, and was out of reach in a basin sitting on top of a metal shelf above the sink. NA-D reported she had just brought in the new toothbrush that morning for R9 to use, but had not gone back to set up the toothbrush, or check with R9 to see if oral cares had in fact been completed. NA-D searched for R9's dentures in white plastic standing drawers to the left of the sink, reporting the dentures should have been in there, and R9 rinses them herself. NA-D went over to R9 who stated she did not have dentures.

During interview on 4/26/17, at 11:31 a.m. NA-E stated R9 wore dentures only when she wanted to and was constantly moving the dentures around in her room. NA-E stated staff would set R9 up for her oral cares, then R9 would brush some, and staff would assist R9 to finish if she needed help. NA-E thought R9's oral cares had been competed shortly after R9 got up that morning, stating her partner, NA-D, had set R9 up for oral cares. NA-E was not aware NA-D had not completed oral cares either. NA-E reported the nurses assistants did not chart specifically on oral cares, just if ADLs had been completed.

During interview on 4/26/17, at 1:13 p.m. registered nurse (RN)-B stated R9 just had upper dentures, staff did a quarterly and annual assessments, and R9 always refused dental

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F 312	Continued From page 9 visits. RN-B stated R9 only needed set up assistance and supervision with oral cares, but would have expected the nursing assistants to go back, made sure R9 completed oral cares, and provided assistance with brushing if she needed it. RN-B reported R9's oral cares were suppose to be done every morning and evening with cares. RN-B further reported staff only documented oral cares during certain times, before assessment periods of the MDS, and would otherwise document oral cares under "as needed" cares. RN-B stated the expectation was that nursing assistants communicated cares with one another, and both were responsible for documenting cares. RN-B observed R9 was not wearing dentures and during the observation, R9 pulled her dentures out of the top drawer of the bedside table. RN-B stated she would only expect staff to update her of R9 not wearing dentures if R9 was having pain or difficulty eating, not if it was R9's personal choice. During interview on 4/27/17, at 1:59 p.m. the director of nursing (DON) stated residents with dentures or teeth should have as much assistance as they needed to complete oral care. The DON further stated oral cares were to be provided in the morning and evening at a minimum. The DON reported she expected staff to let residents do as much for themselves as they could, to re-approach if refused, and to document care and refusals. A facility policy entitled Teeth, Brushing, revised 10/19/16, directed "A resident should be assisted with brushing his or her teeth based on his or her individual needs."	F 312		
F 314	483.25(b)(1) TREATMENT/SVCS TO	F 314		6/6/17

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F 314 SS=D	Continued From page 10 PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper pressure reduction seating in the wheelchair and stationary chair for 1 of 2 residents (R47),and failed to provide timely repositioning for 1 of 2 residents (R112) at risk for developing pressure ulcers. Findings include: R47's quarterly Minimum Data Set (MDS) dated 2/24/17, indicated R47 had severe cognitive impairments and needed extensive assistance for bed mobility, transfers and toileting. The MDS indicated R47 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least 1 continent void) and frequently incontinent of bowel (2 or more episodes of bowel	F 314	R47□s plan of care has been reviewed and updated to reflect the need for pressure reducing cushions on all his seating arrangements. R112□s plan of care was reviewed and is current. All residents who are at risk for skin impairment have had their care plans reviewed and/or updated as needed with a focus on pressure relieving devices & repositioning. The policy and protocols on skin monitoring and interventions was reviewed and is current. Care Managers will initially audit all care	

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F 314	Continued From page 11 incontinence, but at least one continent bowel movement). The MDS included a diagnosis of dementia. The MDS identified R47 was at risk for developing pressure ulcers and had one Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) that was facility acquired. The MDS identified interventions of a pressure reducing device for chair and bed. R47's Braden Scale (tool used to predict pressure ulcer risk) dated 2/24/17, indicated R47 was at low risk for developing pressure ulcers. R47's Comprehensive Skin assessment dated 2/24/17, indicated R47 was at risk for developing pressure ulcers. The assessment identified risk factors of; "Requires assist to move body for pressure relief, slides down in bed and/or chair, noncompliance with encouraged/ setup repositioning. Non compliance with toileting's and required, and assist of two with transfer." The summary indicated, "[R47] has a small open area to the left side of her gluteal sulcus the opening is 0.2 cm [centimeters] x 0.4 x less than 0.1 cm of depth. Resident has some maceration surrounding the area. Will apply cavilon to area and a foam dressing. Change it every 2 days. Resident is currently using a pressure reducing mattress and cushion in her w/c [wheelchair]." R47's Tissue Tolerance Assessment (assessment to determine appropriate repositioning schedule) indicated R47 needed to be repositioned every two hours while sitting. A progress note dated 3/6/17, at 1:31 p.m. indicated the open area was located on the right gluteal sulcus instead of the left.	F 314	plans to assure appropriate interventions are in place for repositioning and pressure relieving devices. Thereafter, Care Managers will conduct daily audits for repositioning compliance, focusing on timeliness and the presence of pressure relieving devices through PCC documentation. Additionally, Care Managers will conduct observational audits of 10% of those residents identified with repositioning needs to assure compliance with documentation & care plan interventions for pressure relieving devices daily for 7 days. Thereafter, these audits will continue 2X weekly for 2 weeks & then 1X/week on varied days for 30 days or until 100% compliance is achieved. Individual audits wll be conducted on an ongoing basis at the time of the residents MDS observational period. All staff providing personal care to residents shall be educated on the need to complete care plan interventions as directed on 5/22/2017 and 5/23/2017. A repositioning & device tracking/audit tool will be used for monitoring. DON or designee shall compile audit data. Results of monitoring activities will be submitted monthly to the QA Committee for review and recommendations.	

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R47's care plan dated 4/12/17, indicated R47 was at risk for skin integrity related to infrequent bladder incontinence, advancing dementia, thin fragile skin, history of healed right buttock wound. Interventions included GEO mattress as a pressure reducing device and a pressure reducing cushion in the recliner when sitting in it. R47's fall risk care plan dated 11/16/16, indicated R47 should be assisted to a stationary chair throughout the day. The care plans did not address a pressure reducing cushion in the wheelchair or stationary chair other than the recliner.

During observation on 4/24/17, at 4:52 p.m. to 7:22 p.m. R47 was observed to be seated in her wheelchair without a pressure reducing cushion in place, the pressure reducing cushion for the wheelchair was in the recliner in the day room.

During observation on 4/25/17, at 8:09 a.m. R47 was observed in the dining room seated on a stationary dining room chair without any pressure reducing cushion.

During observation on 4/26/17, at 7:53 a.m. nursing assistants (NA)-A and NA-B transferred R47 from the recliner in the day room into her wheelchair, without a pressure reducing cushion. NA-A and NA-B wheeled R47 into her bathroom and transferred her to the toilet and did morning cares with R47. After cares were finished NA-A and NA-B transferred R47 back into her wheelchair without any pressure reducing cushion. At 8:15 a.m. NA-C knocked and entered R47's room and stated to NA-A that she would sit with R47 while waiting for her medications to be administered. After medications were

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administered R47 was brought out to the day room in her wheelchair without the cushion. At 8:58 a.m. NA-A wheeled R47 back to her room and did oral cares for R47 and R47 continued to sit in the the wheelchair without a cushion. At 9:06 a.m. R47 was transported via wheelchair to the dining room and NA-A and NA-B transferred R47 into a stationary dining chair without any pressure reducing cushion in place. When R47 was finished eating breakfast at 10:29 a.m. NA-B and NA-C transferred R47 back into her wheelchair, the pressure reducing cushion was seated on the wheelchair.

During interview on 4/26/17, at 1:29 p.m. NA-A stated R47 was transferred in a stationary chair at meals to reduce her falls and stated that the cushion was not in R47's wheelchair when she was sitting in it. NA-A stated that since R47 sat in the recliner a lot and the cushion was care planned to be in the recliner it was forgot and not transferred over to the wheelchair.

During observation on 4/27/17, at 8:37 a.m. R47 was seated in the dining room on a stationary dining chair without and pressure reducing cushion.

During observation on 4/27/17, at 10:03 a.m. licensed practical nurse (LPN)-A assessed R47's buttocks and it was slightly pink but blanchable. R47's buttocks did not have any pressure ulcers. LPN-A applied a barrier spray to her buttocks.

During interview on 4/27/17, at 12:52 p.m. registered nurse (RN)-A stated that R47 had a Stage 2 pressure ulcer recently heal. RN-A stated that R47 should not be sitting in her wheelchair without a pressure reducing cushion because

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F 314	Continued From page 14 there is nothing to redistribute her weight and could cause a pressure ulcer to develop. RN-A further stated R47 was to be transferred into a stationary chair while in the dining room as a fall intervention. RN-A had never done a tissue tolerance assessment for R47 while sitting on a regular dining room chair. RN-A added the stationary chair was not pressure relieving and needed to be re-evaluated. During interview on 4/27/17, at 1:46 p.m. the director of nursing (DON) stated that a pressure relieving cushion should be in the wheelchair when in use and that a stationary chair would not be considered pressure reducing. R112's admission MDS dated 12/21/16, indicated diagnoses of arthritis, osteoporosis and Alzheimer's disease. The MDS also indicated R112 required extensive assist of two with bed mobility, transfers, and locomotion, was at risk for developing pressure ulcers and had severe cognitive impairment. R112's care plan revised on 12/30/16, indicated R112 had a deficit in self care related to dementia, confusion, impaired balance, impaired mobility, weakness and required assistance with bathing, bed mobility, dressing and repositioning every 2 hours and as needed. R112's Braden Scale For Predicting Pressure Score Risks dated 3/20/17, indicated R112 was at moderate risk for skin breakdown and that mobility was very limited. In addition, R112's Comprehensive Skin Assessment dated 3/20/17,	F 314		

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indicated R112 was at risk for skin breakdown.

During continuous observation on 4/26/17, starting at 6:45 a.m. R112 was sitting in her wheelchair in the common area between the 300 and 400 units, close to the nurses station. At 7:45 a.m. R112 was pushed in her wheelchair to the beauty shop, where she remained in her wheelchair. At 8:20 a.m. nursing staff pushed her to the dining room for breakfast. Following breakfast, nursing staff returned R112 back to the commons area still sitting in her wheelchair. At 10:07 a.m. NA-F brought R112 into the tub room in the 400 hall. NA-F asked another NA to assist her in toileting R112. LPN-D entered the tub room with R112 along with the 2 NAs. Although R112's husband declined allowing this surveyor direct observation of R112's bottom, LPN-D reported her skin was intact.

During interview on 4/26/17, at 10:21 a.m. NA--F stated R112 was last toileted and repositioned at approximately 6:30 a.m. when they got her up in the morning and they were not able to get to her again until after 10:00 a.m. (3.5 hours) NA-F stated the reason they were later in getting to her today was that the other NA got pulled to the memory care unit. NA-F stated normally they would have toileted R112 by 9:00 a.m., right after breakfast and would have repositioned R112 every 2 hours. NA-F added that since the other NA was pulled away today, she (NA-F) was doing the best she could. NA-F further stated that R112's care plan did indicate that R112 should be repositioned every 2 hours due to her risk for skin breakdown.

During interview on 4/26/17, at 11:29 a.m. LPN-D stated R112 was toileted and repositioned later

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F 314	Continued From page 16 then normal. LPN-D further stated that per the care plan, R112 should be repositioned every 2 hours, however, that morning it was not done in accordance with the care plan. LPN-D stated R112 could be at risk for skin breakdown when she is not repositioned at least every 2 hours. In addition, LPN-D stated R112 is not able to reposition herself in her chair and that staff did not get to her because they were short an aide. During interview on 4/26/17, at 12:57 p.m. the DON stated it was "not good" that R112 did not get repositioned. The DON stated R112 was at risk due to possible moisture and skin breakdown. The DON stated R112 depended on staff for repositioning and it was her expectation that the NAs either walkie another NA or herself to assist when they are not able to complete cares and hoped they were communicating with each other when they cannot get to someone. Facility policy Prevention of Pressure Ulcers revision date of 6/9/16, indicated, "Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation..."	F 314		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 332	R57 & R43□s MAR & provider orders	6/6/17

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F 332	Continued From page 17 review, the facility failed to ensure 2 of 7 residents (R57, R43) medication was given with food as ordered/directed. This resulted in a facility medication error rate of 6.9 percent. Findings include: R57's annual Minimum Data Set (MDS) dated 1/26/17, indicated R57 had severe cognitive impairment. The MDS included a diagnosis of gastroesophageal reflux disease and had a feeding tube. R57's Order Summary Report signed by the physician on 3/10/17, included an order to administer calcium carbonate suspension 1250 milligrams (mg)/ 5 milliliters (mL) by mouth (PO) or gastrostomy tube (g-tube) three times a day with meals. The summary also included a diagnosis of hypocalcemia. During observation on 4/25/17, at 11:08 a.m. licensed practical nurse (LPN)-B administered 5 ml of calcium carbonate suspension via R57's g-tube. Food was not provided at the time the medication was administered During interview on 4/25/17, at 11:22 a.m. LPN-B stated that the physician's orders in the electronic medication administration record (EMAR) directed staff to administer the calcium carbonate suspension three times a day with food. LPN-B further stated that by not administrating the medication as directed it could make R57 nauseated and the medication was administered too soon before lunch. During interview on 4/27/17, at 1:44 p.m. the director of nursing (DON) stated medications not	F 332	have been reviewed and are current. All residents that require special indications for taking their medications have had their MAR reviewed to assure special indications are addressed. The policy on Administering Medications was reviewed and is current. DON or designee[s] will conduct daily observational audits during med passes, on various shifts, documenting med administrations for residents that require meds taken with food daily for 7 days. Thereafter, audits will be conducted 3X weekly on various shifts for 2 weeks. If 100% compliance is achieved, random, observational audits will be continued monthly X90 days. The Nursing Department will be educated on Administering Medications, specifically administering medications to be given with food. Education will be completed for nursing staff responsible for administering medications on 5/22/2017 and 5/23/2017. Results of the random bi-weekly audits will be submitted monthly to the QA meeting for review and recommendations.	

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given as directed were considered a medication error. The DON further stated that if a medication is ordered or directed to be given with food then the medication should be given with a meal or snack.

The Drug Education Monograph dated 2017, directed calcium carbonate suspension be taken with meals.

R43's admission MDS dated 11/09/16, indicated a diagnosis of gastroesophageal reflux disease

R43's Order Summary Report signed by the physician on 3/3/17, indicated a diagnosis of hypokalemia and included an order to administer potassium chloride 30 milliequivalents (mEq) by mouth one time a day. The order included instructions that the potassium chloride was to be given with food.

During observation on 4/26/17, at 7:10 a.m. LPN-C administered 30 mEq of potassium chloride by mouth to R43, however, food was not provided at the time the medication was administered.

During interview on 4/26/2017, at 7:54 a.m. LPN-C stated that R43 was still in his room and that he had not gone to the dining room yet for breakfast. LPN-C reviewed the order in EMAR for potassium chloride and stated the dose was ordered as 30 mEq and that the instructions in EMAR indicate that this medication should be given with food. LPN-C stated that she had never noticed these instructions before. In addition, she stated her understanding of these instructions is that the medication should be given immediately

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F 332	Continued From page 19 prior to eating and that she would go and get him some toast right now. LPN-C then left the area and returned shortly after with toast for R43. The facility policy Medication Error and Adverse Drug Reaction Report dated 4/24/15, defined a medication error as, " An incorrect medication prescribed, dispensed, or administered to a resident; an omission of a vital medication due to prescribing, dispensing, or administering error; medication administered to an individual with a documented allergy to the at medication."	F 332		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage,	F 371		6/6/17

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F 371	Continued From page 20 handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food prepared in the kitchen for an activity was handled in a manner which reduced the risk of food borne illness. This had the potential to affect 27 out of 65 residents who attended the activity, their families and visitors who also attended the activity. Findings include: During observation on 4/26/17, at 1:57 p.m. therapeutic recreation assistant (TRA)-A was observed deep frying donuts in the kitchen for an activity. Multiple raw donuts cut outs and raw donuts hole cut outs rested on a metal sheet pan on the counter to TRA-A's left and a sheet of fried ready to eat donuts with two bowels of sugar were resting directly in front of TRA-A. Although, TRA-A wore a hairnet, she was not wearing gloves. TRA-A was observed picking up raw donuts with her bare hands, placing them in the two deep fryer baskets, turned them around in the fryer oil with tongs, and used the basket handle to pour the fried donuts into a metal bowel. She then took the metal bowel and set it on the right side of the metal pan with the ready to eat donuts. Without washing her hands after touching raw dough, TRA-A proceeded to pick up the ready to eat donuts which had just come out of the fryer and dipped them in the sugar, before placing them on the metal pan with the other ready to eat donuts. There were approximately 15 donuts already prepared. TRA-A was observed to begin the process over again before she was interrupted by the surveyor.	F 371	The policy on Authorized Personnel in the Kitchen was revised and is current on May 11, 2017. The policy on Hand Washing and Glove Use was also reviewed and is current. The policy on Temperatures and Safe Food Handling was reviewed and updated on May 17, 2017. On-going compliance: Therapeutic Recreation Staff will be provided education on Authorized Personnel in the kitchen, Hand Washing and Glove Use and Temperatures and Safe Food Handling. Education was completed for the Therapeutic Recreation Staff on May 18, 2017. The Therapeutic Recreation Director will do weekly audits on Handwashing and Glove Use and Safe Food Handling during recreation department activities involving food for 3 weeks of all TR staff. Thereafter, random audits will be conducted at least monthly for three months. Results of the audits will be submitted monthly to the QA meeting for review and recommendations. Therapeutic Recreation Director and/or designee will be responsible for ongoing compliance.	

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F 371	Continued From page 21 During interview on 4/26/17, at 1:57 p.m. TRA-A stated the donuts were made every fourth Wednesday of the month, their "donut day," when a band came to play for the residents and their families. She further stated the donut dough was made from scratch for the activities staff and contained raw eggs in it. TRA-A stated the activities staff before her did not use gloves and asked, "Am I suppose to?" TRA-A reported, "I'm only doing it the way the person prior to me did it," stating activities staff always made the donuts for donut day. She further stated,"I would suppose it would be an issue to touch the donuts after raw dough," reporting she should wear gloves so "you don't transfer the raw ingredients." During observation on 4/26/17, at 2:15 p.m. TRA-A was now observed wearing clear plastic gloves, however, she continued to pick up raw donuts, placed them in the two deep fryer baskets, turned them around in the fryer oil with tongs, and used the basket handle to pour the fried donuts into a metal bowel, and proceeded to pick up the ready to eat donuts to dip them in the sugar without changing gloves in between handling raw donut dough and ready to eat donuts. During interview on 4/26/17, at 2:15 p.m. TRA-A appeared confused stating she was doing the same process and touching raw dough, just with gloves on. TRA-A did not know how to fix the process. During the interview, at 2:21 p.m. the certified dietary manager (CDM) walked into the kitchen and assisted TRA-A to find a metal spatula and new tongs to use, stating TRA-A needed to wash her hands and change her gloves in between touching raw dough and ready	F 371		

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F 371	Continued From page 22 to eat donuts or use the utensils and not touch the dough at all. During interview on 4/26/17, at 2:38 p.m. the CDM stated activities puts on their donut day every month and was usually in care conferences all afternoon so she had not seen the activities staff make the donuts in the kitchen until that day. The CDM stated the activities staff only used the kitchen for donut day and TRA-A should have know that was not okay. The CDM reported the activities supervisor knew gloves were to be worn. The CDM stated ready to eat foods could not be touched with bare hands because of cross contamination and transferring the germs on your hands onto the food that is going to be eaten, stating she taught "if you are going to eat it don't touch it." The CDM further stated ready to eat food should not be touched after touching raw food, and even if wearing gloves cannot touch raw then cooked food, because there are raw eggs in the dough. During interview on 4/26/17, at 2:49 p.m. the therapeutic recreation director (TRD) stated the activity staff were in charge of making donuts and the staff were taught to wear gloves and a hairnet, but thought it was a bit hard to fry the donuts with the plastic gloves on due to the hot oil. The TRD stated everything else was pre-made for the activities except the donuts and she had not been aware of any issues with frying the donuts. A facility policy entitled Hand Washing And Glove Use, revised 4/26/17, directed, "Gloves may be used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food."	F 371		

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F 371	Continued From page 23 A facility policy entitled Temperatures And Safe Food Handling, undated, identified food-borne illnesses could be caused due to raw foods contaminating ready to eat or cooked foods. In addition, the policy directed to used tongs and not handle food with bare hands for proper food handling.	F 371		

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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, State Fire Marshal Division. At the time of this survey, Foley Health Center, Building 01 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 55101-5145, or By e-mail to both:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/19/2017

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	**253 PINE STREET** **FOLEY, MN 56329**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as 1 building: Foley Nursing Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1970 and was determined to be of Type II(222) construction. In 1976, an addition was added to the north that was determined to be of Type V(111). In 1994 additions were added to the west of Units 2 & 4, additions to the Kitchen and Dining Room that were determined to be of Type II(000) construction and a Chapel addition to west of Unit 2 which was determined to be Type V(111) construction. In 2008 two additions were added to the facility , the North wing determined to be of type II(111) construction and the PT/OT addition determined to be of type II(111). This building is partially fire sprinkler protected due to a K351 deficiency. The entire facility has a	K 000		

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	245325	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/26/2017**

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K 000	Continued From page 2 complete addressable fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has a licensed capacity of 89 beds and had a census of 66 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=D	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 4 - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.1.1.4. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect	K 133	Maintenance has applied Fire Caulk to the penetrations by the beauty shop around communication wires that are passing through the fire barrier wall section above ceiling tile over the fire barrier doors with a fire rated wall structure to ensure the safety of our	5/18/17

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K 133	Continued From page 3 20 of 66 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 04/26/2017, observations revealed that the fire door by the beauty shop had penetrations around communication wires that are passing through the fire barrier wall section above the ceiling tile over the fire barrier doors. This deficient condition was verified by a Maintenance Supervisor.	K 133	residents, visitors and staff. A policy/procedure will be implemented by the Environmental Service Director when there is any above ceiling construction done, that penetrates the barrier. This was completed on: 5/18/2017 This plan of correction constitutes our allegation of compliance.	
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222		5/18/17

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K 222	Continued From page 4 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 222	The Director of Environmental Services	

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K 222	Continued From page 5 facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.2.2 and 7.2.1.6 and the 2015 MN State Fire Code, Appendix I. This deficient practice could affect 12 of 66 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 04/26/2017, Observation revealed that the exit door located at the stairwell exit by resident room 510 has a coded keypad used to unlock the door to the exit, but did not have a the code or instructions on how to open the door posted at the location of the keypad. This deficient condition was verified by a Maintenance Supervisor.	K 222	will place and monitor instructions on how to open the door with the keypad by the exit door located at the stairwell by resident room 510. This was completed on: 5/18/2017 This plan of correction constitutes our allegation of compliance.	
K 351 SS=F	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as	K 351		6/16/17

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K 351	Continued From page 6 required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 6 of 66 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 04/26/2017, observations revealed the following deficient conditions, 1. The sprinkler piping that is located in the maintenance office had wires attached to the piping. 2. The facility has a enclosure type of canopy that is constructed of combustible wood frame construction attached to the building over the exterior exit stairwell from the lower level boiler room that is not fire sprinkler protected. This deficient condition was verified by a Maintenance Supervisor.	K 351	1.Maintenance removed and will monitor the sprinkler piping that is located in the maintenance office which had wires attached. This was completed on: 4/26/2017 This plan of correction constitutes our allegation of compliance. 2. Summit Fire Protection will install and monitor a sprinkler system in the enclosure type of canopy that is constructed of combustible wood frame construction attached to the building over the exterior exit stairwell from the lower level boiler room that is not fire sprinkled. Completion Date: 6/16/2017 This plan of correction constitutes our allegation of compliance.	
K 372	NFPA 101 Subdivision of Building Spaces -	K 372		5/18/17

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K 372 SS=D	Continued From page 7 Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 of 5 several smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 66 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 04/26/2017, observations revealed that there were multiple penetrations found around the conduit and communication wires that are passing through the smoke barrier wall above the ceiling tiles in the care manager's office section of the smoke barrier wall. This deficient condition was verified by a	K 372	Maintenance has applied Fire Caulk to the penetrations found around the conduit and communication wires that are passing through the smoke barrier wall above the ceiling tiles in the care manager's office section of the barrier wall. A policy/procedure policy will be implemented by the Environmental Director when there is any above ceiling construction done, that penetrates the barrier. Completion Date: 5/18/2017 This plan of correction constitutes our allegation of compliance.	

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K 372	Continued From page 8 Maintenance Supervisor.	K 372		
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition. This deficient practice could affect 6 of 66 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 04/26/2017, observations revealed that there were multi-plug adaptors and multiple extension cords in use in the maintenance office. This deficient condition was verified by a Maintenance Supervisor.	K 511	Maintenance has removed and will monitor the multi-plug adapters and multiple extension cord in the maintenance office. Completion Date: 4/26/2017 This plan of correction constitutes our allegation of compliance.	4/26/17
K 521	NFPA 101 HVAC	K 521		5/19/17

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K 521 SS=F	Continued From page 9 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90A(12) section 5-1.2 and 5.2. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect 66 of 66 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 04/26/2017, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and confirmed by an interview with the Maintenance Supervisor, that the facility could not provide any current testing documentation verifying that the fire and smoke dampers has been tested or inspected within the last 4 years. This deficient condition was verified by a Maintenance Supervisor.	K 521	Summit Fire Protection will test/inspect the facility's fire and smoke dampers with documentation of the inspection. This test/inspection with documentation will follow every 4 years there after. Director of Environmental Service will monitor to insure that test/inspection is scheduled. Completion Date: 5/19/2017 This plan of correction constitutes our allegation of compliance.	

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K 781	Continued From page 10	K 781		
K 781 SS=F	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.8. This deficient practice could affect 66 of 66 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 a.m. to 1:30 p.m. on 04/26/2017, observations and staff interview revealed that the facility has a fire place space heater being used in the medical records office. When the space heater was turned on, a temp reading was taken with a heat detection gun at the vent discharge screen of 227 degrees F. It also did not have a Underwriter's Laboratory (UL) listing annotated anywhere on the device. It was also discovered at the time of the discovery the Maintenance Supervisor was asked if the facility had a policy for the use of space heaters and he stated, "we don't have a space heater use policy". At the time of the inspection the facility could not provide any space heater policy.	K 781	Maintenance removed the space heater with a temp reading of 227 degrees F and no UL Listing. Director of Environmental Services has composed a policy for the use of space heaters at Foley Nursing Center. Completion Date: 4/26/2017 This plan of correction constitutes our allegation of compliance.	4/26/17

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K 781	Continued From page 11 This deficient condition was verified by a Maintenance Supervisor.	K 781		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 10, 2017

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5325026

Dear Mr. Huhta:

The above facility was surveyed on April 24, 2017 through April 27, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 Kathy Lucas at (320)223-7343 or Kathleen.Lucas@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.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: _____ B. WING _____	C 04/27/2017

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FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000	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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	00629	A. BUILDING: _____ B. WING _____	C 04/27/2017

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 04/24/2017 - 04/27/2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview, observation and document review, the facility failed to provide timely	2 565	Care plans for R112 & R9 have been reviewed and updated as needed to reflect	6/6/17

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2 565	Continued From page 2 repositioning for 1 of 3 residents (R112), and failed to provide oral care for 1 of 3 residents (R9) reviewed for following the care plan. Findings include: R112's admission Minimum Data Set (MDS) indicated R112 required extensive assist of two with transfers and bed mobility, was at risk for developing pressure ulcers and had severe cognitive impairment. R112's care plan revised on 12/30/16, indicated R112 had a deficit in self care related to dementia, confusion, impaired balance, impaired mobility, weakness and required assistance with toileting and repositioning every 2 hours and as needed. During continuous observation on 4/26/17, starting at 6:45 a.m. R112 was sitting in her wheelchair in the common area between the 300 and 400 units, close to the nurses station. At 7:45 a.m. R112 was pushed in her wheelchair to the beauty shop, where she remained in her wheelchair. At 8:20 a.m. nursing staff pushed her to the dining room for breakfast. Following breakfast, nursing staff returned R112 back to the commons area still sitting in her wheelchair. At 10:07 a.m. Nursing assistant (NA)-F brought R112 into the tub room in the 400 hall. NA-F asked another NA to assist her in toileting R112. Licensed practical nurse (LPN)-D entered the tub room with R112 along with the 2 NAs and toileting/repositioning was provided. During interview on 4/26/17, at 10:21 a.m. NA--F stated R112 was last toileted and repositioned at approximately 6:30 a.m. when they got her up in the morning and they were not able to get to her	2 565	current status. All residents who are dependent on staff for ADL assist and repositioning have had their care plans reviewed and/or updated as needed. The policy and protocols on repositioning and oral cares was reviewed and is current. Care Managers will initially audit all care plans to assure appropriate interventions are in place for oral hygiene and needed repositioning assistance. Thereafter, Care Managers will conduct daily audits of ADL□s and repositioning timeliness through PCC documentation. Additionally, Care Managers will conduct observational audits of 10% of those residents identified with oral & repositioning needs to assure compliance with documentation & care plan interventions daily for 7 days. Thereafter, these audits will continue 2X weekly for 2 weeks & then 1X/week on varied days for 30 days or until 100% compliance is achieved. Individual audits will be conducted on an ongoing basis at the time of the residents MDS observational period. All staff providing personal care to residents shall be educated on the need to complete care plan interventions as directed on 5/22/2017 and 5/23/2017. A repositioning and oral cares tracking/audit tool will be used for monitoring. DON or designee shall compile audit data. Results of monitoring activities will be submitted monthly to the	

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2 565	Continued From page 3 again until after 10:00 a.m. (3.5 hours). NA-F stated the reason they were later in getting to her today was that the other NA got pulled to the memory care unit. NA-F stated normally they would have toileted R112 by 9:00 am, right after breakfast and would have repositioned R112 every 2 hours, but since the other NA was pulled away today, she (NA-F) was doing the best she could. NA-F further stated that R112's care plan indicated R112 should be repositioned every 2 hours due to her risk for skin breakdown. During interview on 4/26/17, at 11:29 a.m. LPN-D stated R112 was toileted and repositioned later then normal. LPN-D further stated that per the care plan, R112 should be repositioned every 2 hours, however, that morning it was not done in accordance with the care plan. LPN-D stated R112 could be at risk for skin breakdown when she is not repositioned at least every 2 hours. During interview on 4/26/17, at 12:57 p.m. the director of nursing (DON) stated it was "not good" that R112 did not get repositioned. The DON stated R112 was at risk due to possible moisture and skin breakdown. The DON stated R112 depended on them for repositioning and it was her expectation that the NA's either walkie another NA or herself to assist when they are not able to complete cares and hoped they were communicating with each other when they can not get to someone. Facility policy Comprehensive Care Plan revision date of 11/16/16, indicated the purpose of the policy, "Is to develop and implement a comprehensive care plan that is person centered for each resident and consistent with resident rights, to ensure we provide the necessary care and services to attain or maintain the highest	2 565	QA Committee for review and recommendations. Date of Completion: June 6, 2017	

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2 565	Continued From page 4 possible physical, mental and psychosocial well being, consistent with the resident's comprehensive assessment." R9's annual MDS dated 11/15/16, identified a moderate cognitive impairment, needed extensive assistance with personal hygiene including brushing her teeth, and was edentulous (had no teeth). R9's current care plan dated 2/14/17, identified an ADL (activities of daily living) self-care deficit due to muscle weakness and pain, indicating she needed extensive assistance from one staff with personal hygiene, but could complete oral cares independently once set up. The care plan identified R9 had upper dentures and directed oral cares were suppose to be done in the morning and evening, identified, "[R9] is able to rinse dentures and rinse mouth with mouthwash independently after setup." R9's Bedside Kardex report, dated 4/27/17, again identified she wore upper dentures, oral care was provided morning and evenings, and could complete oral care independently after setup. During interview on 4/24/17, at 6:40 p.m. R9 stated she did not receive any assistance with oral cares and did not have any dentures. During interview, R9 was observed without teeth or dentures in her mouth. During observation on 4/26/17, at 7:18 a.m. R9's morning cares were being finished. NA-D and NA-E were observed to transfer R9 from her bed to the wheelchair using a PAL lift (mechanical lift to help sit to stand). R9 was already dressed and once in the wheelchair, NA-E asked if R9 needed to use the restroom. R9 was brought out of her	2 565		

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2 565	Continued From page 5	2 565		

room into a larger bathroom. After toileting, R9 was brought back into her room, NA-E left the room, and NA-D made R9's bed. R9 asked for her lipstick and after giving R9 her lipstick, NA-D proceeded to ask R9's roommate (R28) if she wanted to complete oral cares. NA-D left the room and returned with two new toothbrushes, one for R9 and one for R28. NA-D assisted R28 with her oral cares, then asked R9 if she wanted to brush her teeth before or after breakfast. R9 responded she wanted to brush after breakfast.

During continuous observation on 4/26/17, at 8:37 a.m. R9 was just finishing breakfast in the dining room. A couple of minutes later at 8:39 a.m. an unidentified staff member took R9 from the dining room back to her room. No oral cares were provided. At 9:12 a.m. R9 continued to sit in her room, listening to music on a radio. At 9:40 a.m. R9 was observed in her room and did not have dentures in her mouth. And at 9:59 a.m. R9 continued to be in her room. No oral cares were provided after breakfast.

During interview on 4/26/17, at 10:34 a.m. NA-D stated staff would get R9 dressed, and R9 would finish up brushing her hair, applying her make up, and brushing her teeth. NA-D stated R9 did her own oral care around 9:00 a.m. that morning after breakfast, however, when NA-D observed R9's bathroom during the interview, R9's new toothbrush had not been touched, was still sealed in the original wrapper, and was out of reach in a basin sitting on top of a metal shelf above the sink. NA-D reported she had just brought in the new toothbrush that morning for R9 to use, but had not gone back to set up the toothbrush, or check with R9 to see if oral cares had in fact been completed. NA-D searched for R9's dentures in white plastic standing drawers to the

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2 565	Continued From page 6 left of the sink, reporting the dentures should have been in there, and R9 rinses them herself. NA-D went over to R9 who stated she didn't have dentures. During interview on 4/26/17, at 11:31 a.m. NA-E stated R9 wore dentures only when she wanted to and was constantly moving the dentures around in her room. NA-E stated staff would set R9 up for her oral cares, then R9 would brush some, and staff would assist R9 to finish if she needed help. NA-E thought R9's oral cares had been competed shortly after R9 got up that morning, stating her partner, NA-D, had set R9 up for oral cares. NA-E was not aware NA-D had not completed oral cares either. During interview on 4/26/17, at 1:13 p.m. registered nurse (RN)-B stated R9 only needed set up assistance and supervision with oral cares. RN-A stated she would have expected the nursing assistants to go back, made sure R9 completed oral cares, and provided assistance with brushing if she needed it. RN-B reported R9's oral cares were suppose to be done every morning and evening with cares. During interview on 4/27/17, at 1:59 p.m. the DON stated residents with dentures or teeth should have as much assistance as they needed to complete oral care. The DON further stated oral cares were to be provided in the morning and evening at a minimum. A facility policy entitled Teeth, Brushing, revised 10/19/16, directed, "A resident should be assisted with brushing his or her teeth based on his or her individual needs."	2 565		

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2 565	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and /or revise policies and procedures related to the implementation of the care plan to ensure care is provided as directed by the care plan. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) days.	2 565		
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: Based on observation, interview and document review, the facility failed to ensure proper	2 900	R47□s plan of care has been reviewed and updated to reflect the need for	6/6/17

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2 900	Continued From page 8 pressure reduction seating in the wheelchair and stationary chair for 1 of 2 residents (R47),and failed to provide timely repositioning for 1 of 2 residents (R112) at risk for developing pressure ulcers. Findings include: R47's quarterly Minimum Data Set (MDS) dated 2/24/17, indicated R47 had severe cognitive impairments and needed extensive assistance for bed mobility, transfers and toileting. The MDS indicated R47 was frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least 1 continent void) and frequently incontinent of bowel (2 or more episodes of bowel incontinence, but at least one continent bowel movement). The MDS included a diagnosis of dementia. The MDS identified R47 was at risk for developing pressure ulcers and had one Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough) that was facility acquired. The MDS identified interventions of a pressure reducing device for chair and bed. R47's Braden Scale (tool used to predict pressure ulcer risk) dated 2/24/17, indicated R47 was at low risk for developing pressure ulcers. R47's Comprehensive Skin assessment dated 2/24/17, indicated R47 was at risk for developing pressure ulcers. The assessment identified risk factors of; "Requires assist to move body for pressure relief, slides down in bed and/or chair, noncompliance with encouraged/ setup repositioning. Non compliance with toileting's and required, and assist of two with transfer." The summary indicated, "[R47] has a small open area to the left side of her gluteal sulcus the opening is	2 900	pressure reducing cushions on all his seating arrangements. R112□s plan of care was reviewed and is current. All residents who are at risk for skin impairment have had their care plans reviewed and/or updated as needed with a focus on pressure relieving devices & repositioning. The policy and protocols on skin monitoring and interventions was reviewed and is current. Care Managers will initially audit all care plans to assure appropriate interventions are in place for repositioning and pressure relieving devices. Thereafter, Care Managers will conduct daily audits for repositioning compliance, focusing on timeliness and the presence of pressure relieving devices through PCC documentation. Additionally, Care Managers will conduct observational audits of 10% of those residents identified with repositioning needs to assure compliance with documentation & care plan interventions for pressure relieving devices daily for 7 days. Thereafter, these audits will continue 2X weekly for 2 weeks & then 1X/week on varied days for 30 days or until 100% compliance is achieved. Individual audits wll be conducted on an ongoing basis at the time of the residents MDS observational period. All staff providing personal care to residents shall be educated on the need to complete care plan interventions as directed on 5/22/2017 and 5/23/2017.	

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2 900	Continued From page 9 0.2 cm [centimeters] x 0.4 x less than 0.1 cm of depth. Resident has some maceration surrounding the area. Will apply cavilon to area and a foam dressing. Change it every 2 days. Resident is currently using a pressure reducing mattress and cushion in her w/c [wheelchair]." R47's Tissue Tolerance Assessment (assessment to determine appropriate repositioning schedule) indicated R47 needed to be repositioned every two hours while sitting. A progress note dated 3/6/17, at 1:31 p.m. indicated the open area was located on the right gluteal sulcus instead of the left. R47's care plan dated 4/12/17, indicated R47 was at risk for skin integrity related to infrequent bladder incontinence, advancing dementia, thin fragile skin, history of healed right buttock wound. Interventions included GEO mattress as a pressure reducing device and a pressure reducing cushion in the recliner when sitting in it. R47's fall risk care plan dated 11/16/16, indicated R47 should be assisted to a stationary chair throughout the day. The care plans did not address a pressure reducing cushion in the wheelchair or stationary chair other than the recliner. During observation on 4/24/17, at 4:52 p.m. to 7:22 p.m. R47 was observed to be seated in her wheelchair without a pressure reducing cushion in place, the pressure reducing cushion for the wheelchair was in the recliner in the day room. During observation on 4/25/17, at 8:09 a.m. R47 was observed in the dining room seated on a stationary dining room chair without any pressure reducing cushion.	2 900	A repositioning & device tracking/audit tool will be used for monitoring. DON or designee shall compile audit data. Results of monitoring activities will be submitted monthly to the QA Committee for review and recommendations.	

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2 900	Continued From page 10 During observation on 4/26/17, at 7:53 a.m. nursing assistants (NA)-A and NA-B transferred R47 from the recliner in the day room into her wheelchair, without a pressure reducing cushion. NA-A and NA-B wheeled R47 into her bathroom and transferred her to the toilet and did morning cares with R47. After cares were finished NA-A and NA-B transferred R47 back into her wheelchair without any pressure reducing cushion. At 8:15 a.m. NA-C knocked and entered R47's room and stated to NA-A that she would sit with R47 while waiting for her medications to be administered. After medications were administered R47 was brought out to the day room in her wheelchair without the cushion. At 8:58 a.m. NA-A wheeled R47 back to her room and did oral cares for R47 and R47 continued to sit in the the wheelchair without a cushion. At 9:06 a.m. R47 was transported via wheelchair to the dining room and NA-A and NA-B transferred R47 into a stationary dining chair without any pressure reducing cushion in place. When R47 was finished eating breakfast at 10:29 a.m. NA-B and NA-C transferred R47 back into her wheelchair, the pressure reducing cushion was seated on the wheelchair. During interview on 4/26/17, at 1:29 p.m. NA-A stated R47 was transferred in a stationary chair at meals to reduce her falls and stated that the cushion was not in R47's wheelchair when she was sitting in it. NA-A stated that since R47 sat in the recliner a lot and the cushion was care planned to be in the recliner it was forgot and not transferred over to the wheelchair. During observation on 4/27/17, at 8:37 a.m. R47 was seated in the dining room on a stationary dining chair without and pressure reducing	2 900		

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2 900	Continued From page 11 cushion. During observation on 4/27/17, at 10:03 a.m. licensed practical nurse (LPN)-A assessed R47's buttocks and it was slightly pink but blanchable. R47's buttocks did not have any pressure ulcers. LPN-A applied a barrier spray to her buttocks. During interview on 4/27/17, at 12:52 p.m. registered nurse (RN)-A stated that R47 had a Stage 2 pressure ulcer recently heal. RN-A stated that R47 should not be sitting in her wheelchair without a pressure reducing cushion because there is nothing to redistribute her weight and could cause a pressure ulcer to develop. RN-A further stated R47 was to be transferred into a stationary chair while in the dining room as a fall intervention. RN-A had never done a tissue tolerance assessment for R47 while sitting on a regular dining room chair. RN-A added the stationary chair was not pressure relieving and needed to be re-evaluated. During interview on 4/27/17, at 1:46 p.m. the director of nursing (DON) stated that a pressure relieving cushion should be in the wheelchair when in use and that a stationary chair would not be considered pressure reducing. R112's admission MDS dated 12/21/16, indicated diagnoses of arthritis, osteoporosis and Alzheimer's disease. The MDS also indicated R112 required extensive assist of two with bed mobility, transfers, and locomotion, was at risk for developing pressure ulcers and had severe cognitive impairment. R112's care plan revised on 12/30/16, indicated R112 had a deficit in self care related to dementia, confusion, impaired balance, impaired	2 900		

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2 900	Continued From page 12	2 900		

mobility, weakness and required assistance with bathing, bed mobility, dressing and repositioning every 2 hours and as needed.

R112's Braden Scale For Predicting Pressure Score Risks dated 3/20/17, indicated R112 was at moderate risk for skin breakdown and that mobility was very limited. In addition, R112's Comprehensive Skin Assessment dated 3/20/17, indicated R112 was at risk for skin breakdown.

During continuous observation on 4/26/17, starting at 6:45 a.m. R112 was sitting in her wheelchair in the common area between the 300 and 400 units, close to the nurses station. At 7:45 a.m. R112 was pushed in her wheelchair to the beauty shop, where she remained in her wheelchair. At 8:20 a.m. nursing staff pushed her to the dining room for breakfast. Following breakfast, nursing staff returned R112 back to the commons area still sitting in her wheelchair. At 10:07 a.m. NA-F brought R112 into the tub room in the 400 hall. NA-F asked another NA to assist her in toileting R112. LPN-D entered the tub room with R112 along with the 2 NAs. Although R112's husband declined allowing this surveyor direct observation of R112's bottom, LPN-D reported her skin was intact.

During interview on 4/26/17, at 10:21 a.m. NA--F stated R112 was last toileted and repositioned at approximately 6:30 a.m. when they got her up in the morning and they were not able to get to her again until after 10:00 a.m. (3.5 hours) NA-F stated the reason they were later in getting to her today was that the other NA got pulled to the memory care unit. NA-F stated normally they would have toileted R112 by 9:00 a.m., right after breakfast and would have repositioned R112 every 2 hours. NA-F added that since the other

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2 900	Continued From page 13 NA was pulled away today, she (NA-F) was doing the best she could. NA-F further stated that R112's care plan did indicate that R112 should be repositioned every 2 hours due to her risk for skin breakdown. During interview on 4/26/17, at 11:29 a.m. LPN-D stated R112 was toileted and repositioned later then normal. LPN-D further stated that per the care plan, R112 should be repositioned every 2 hours, however, that morning it was not done in accordance with the care plan. LPN-D stated R112 could be at risk for skin breakdown when she is not repositioned at least every 2 hours. In addition, LPN-D stated R112 is not able to reposition herself in her chair and that staff did not get to her because they were short an aide. During interview on 4/26/17, at 12:57 p.m. the DON stated it was "not good" that R112 did not get repositioned. The DON stated R112 was at risk due to possible moisture and skin breakdown. The DON stated R112 depended on staff for repositioning and it was her expectation that the NAs either walkie another NA or herself to assist when they are not able to complete cares and hoped they were communicating with each other when they cannot get to someone. Facility policy Prevention of Pressure Ulcers revision date of 6/9/16, indicated, "Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation..." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could	2 900		

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2 900	Continued From page 14 develop policies and procedure to ensure residents have a comprehensive assessment of the risk for developing pressure ulcers so that individualized interventions could be implemented. The director of nursing or her designee could educate all appropriate staff on the polices and procedures related to pressure ulcers. The director of nursing or her designee could develop a monitoring system to ensure residents are assessed and receive interventions to prevent the development of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were provided assistance with oral cares for 1 of 3 residents (R9) reviewed for activities of daily living (ADLs). Findings include: R9's annual Minimum Data Set (MDS) dated 11/15/16, identified a moderate cognitive impairment, needed extensive assistance with	2 920	R9□s care plan & care sheets have been reviewed and are current. All residents who are dependent on staff for ADL assistance with oral cares have had their care plans reviewed and/or updated as needed. The policy and protocols on oral cares was reviewed and is current. Care Managers will initially audit all care plans to assure appropriate interventions	6/6/17

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2 920	Continued From page 15 personal hygiene including brushing her teeth, and was edentulous (had no teeth). R9's MDS Dental Assessment, dated 2/14/17, indicated she had upper dentures, which R9 reported were loose, but declined a dental appointment. R9's assessment identified no oral concerns, and directed, "Staff assist in denture cares. [R9] is able to complete the rest of her oral cares independently after setup." R9's current care plan dated 2/14/17, identified an ADL self-care deficit due to muscle weakness and pain, indicating she needed extensive assistance from one staff with personal hygiene, but could complete oral cares independently once set up. The care plan identified R9 had upper dentures and directed oral cares were suppose to be done in the morning and evening, and identified "[R9] is able to rinse dentures and rinse mouth with mouthwash independently after setup." R9's Bedside Kardex report dated 4/27/17, identified she wore upper dentures, oral care was provided morning and evenings, and could complete oral care independently after setup. During interview on 4/24/17, at 6:40 p.m. R9 stated she did not receive any assistance with oral cares and did not have any dentures. During interview, R9 was observed without teeth or dentures in her mouth. During observation on 4/26/17, at 7:18 a.m. R9's morning cares were being finished. Nursing assistant (NA)-D and NA-E were observed to transfer R9 from her bed to the wheelchair using a PAL lift (mechanical lift to help sit to stand). R9 was already dressed and once in the wheelchair,	2 920	are in place for oral hygiene assistance. Thereafter, Care Managers will conduct daily audits of ADL□s , focusing on oral hygiene timeliness through PCC documentation. Additionally, Care Managers will conduct observational audits of 10% of those residents identified with oral needs to assure compliance with documentation & care plan interventions daily for 7 days. Thereafter, these audits will continue 2X weekly for 2 weeks & then 1X/week on varied days for 30 days or until 100% compliance s achieved. Individual audits will be conducted on an ongoing basis at the time of the residents MDS observational period. All staff providing personal care to residents shall be educated on the need to complete care plan interventions as directed by 5/22/2017 and 5/23/2017. An oral cares tracking/audit tool will be used for monitoring. DON or designee shall compile audit data. Results of monitoring activities will be submitted monthly to the QA Committee for review and recommendations. Date of Completion: June 6. 2017 .	

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2 920	Continued From page 16 NA-E asked if R9 needed to use the restroom. R9 was brought out of her room into a larger bathroom. After toileting, R9 was brought back into her room, NA-E left the room, and NA-D made R9's bed. R9 asked for her lipstick and after giving R9 her lipstick, NA-D proceeded to ask R9's roommate (R28) if she wanted to complete oral cares. NA-D left the room and returned with two new toothbrushes, one for R9 and one for R28. NA-D assisted R28 with her oral cares, then asked R9 if she wanted to brush her teeth before or after breakfast. R9 responded she wanted to brush after breakfast. During continuous observation on 4/26/17, at 8:37 a.m. R9 was just finishing breakfast in the dining room. A couple of minutes later at 8:39 a.m. an unidentified staff member took R9 from the dining room back to her room. No oral cares were provided. At 9:12 a.m. R9 continued to sit in her room, listening to music on a radio. At 9:40 a.m. R9 was observed in her room and did not have dentures in her mouth. And at 9:59 a.m. R9 continued to be in her room. No oral cares were provided after breakfast. During interview on 4/26/17, at 10:34 a.m. NA-D stated staff would get R9 dressed, and R9 would finish up brushing her hair, applying her make up, and brushing her teeth. NA-D stated R9 did her own oral care around 9:00 a.m. that morning after breakfast, however, when NA-D observed R9's bathroom during the interview, R9's new toothbrush had not been touched, was still sealed in the original wrapper, and was out of reach in a basin sitting on top of a metal shelf above the sink. NA-D reported she had just brought in the new toothbrush that morning for R9 to use, but had not gone back to set up the toothbrush, or check with R9 to see if oral cares had in fact	2 920		

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2 920	Continued From page 17 been completed. NA-D searched for R9's dentures in white plastic standing drawers to the left of the sink, reporting the dentures should have been in there, and R9 rinses them herself. NA-D went over to R9 who stated she did not have dentures. During interview on 4/26/17, at 11:31 a.m. NA-E stated R9 wore dentures only when she wanted to and was constantly moving the dentures around in her room. NA-E stated staff would set R9 up for her oral cares, then R9 would brush some, and staff would assist R9 to finish if she needed help. NA-E thought R9's oral cares had been competed shortly after R9 got up that morning, stating her partner, NA-D, had set R9 up for oral cares. NA-E was not aware NA-D had not completed oral cares either. NA-E reported the nurses assistants did not chart specifically on oral cares, just if ADLs had been completed. During interview on 4/26/17, at 1:13 p.m. registered nurse (RN)-B stated R9 just had upper dentures, staff did a quarterly and annual assessments, and R9 always refused dental visits. RN-B stated R9 only needed set up assistance and supervision with oral cares, but would have expected the nursing assistants to go back, made sure R9 completed oral cares, and provided assistance with brushing if she needed it. RN-B reported R9's oral cares were suppose to be done every morning and evening with cares. RN-B further reported staff only documented oral cares during certain times, before assessment periods of the MDS, and would otherwise document oral cares under "as needed" cares. RN-B stated the expectation was that nursing assistants communicated cares with one another, and both were responsible for documenting cares. RN-B observed R9 was not wearing	2 920		

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2 920	Continued From page 18 dentures and during the observation, R9 pulled her dentures out of the top drawer of the bedside table. RN-B stated she would only expect staff to update her of R9 not wearing dentures if R9 was having pain or difficulty eating, not if it was R9's personal choice. During interview on 4/27/17, at 1:59 p.m. the director of nursing (DON) stated residents with dentures or teeth should have as much assistance as they needed to complete oral care. The DON further stated oral cares were to be provided in the morning and evening at a minimum. The DON reported she expected staff to let residents do as much for themselves as they could, to re-approach if refused, and to document care and refusals. A facility policy entitled Teeth, Brushing, revised 10/19/16, directed "A resident should be assisted with brushing his or her teeth based on his or her individual needs." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for providing oral care needs as directed by the assessed needs of residents and provide education to nursing staff to follow cares as directed by the care plan. The facility could develop and implement an auditing system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi	21015		6/6/17

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21015	Continued From page 19 Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food prepared in the kitchen for an activity was handled in a manner which reduced the risk of food borne illness. This had the potential to affect 27 out of 65 residents who attended the activity, their families and visitors who also attended the activity. Findings include: During observation on 4/26/17, at 1:57 p.m. therapeutic recreation assistant (TRA)-A was observed deep frying donuts in the kitchen for an activity. Multiple raw donuts cut outs and raw donuts hole cut outs rested on a metal sheet pan on the counter to TRA-A's left and a sheet of fried ready to eat donuts with two bowels of sugar were resting directly in front of TRA-A. Although, TRA-A wore a hairnet, she was not wearing gloves. TRA-A was observed picking up raw donuts with her bare hands, placing them in the two deep fryer baskets, turned them around in the fryer oil with tongs, and used the basket handle to pour the fried donuts into a metal bowel. She then took the metal bowel and set it on the right side of the metal pan with the ready to eat donuts. Without washing her hands after touching raw dough, TRA-A proceeded to pick up the ready to eat donuts which had just come out of the fryer and dipped them in the sugar, before placing	21015	The policy on Authorized Personnel in the Kitchen was revised and is current on May 11, 2017. The policy on Hand Washing and Glove Use was also reviewed and is current. The policy on Temperatures and Safe Food Handling was reviewed and updated on May 17, 2017. On-going compliance: Therapeutic Recreation Staff will be provided education on Authorized Personnel in the kitchen, Hand Washing and Glove Use and Temperatures and Safe Food Handling. Education was completed for the Therapeutic Recreation Staff on May 18, 2017. The Therapeutic Recreation Director will do weekly audits on Handwashing and Glove Use and Safe Food Handling during recreation department activities involving food for 3 weeks of all TR staff. Thereafter, random audits will be conducted at least monthly for three months. Results of the audits will be submitted monthly to the QA meeting for review and recommendations. Therapeutic Recreation Director and/or	

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21015	Continued From page 20 them on the metal pan with the other ready to eat donuts. There were approximately 15 donuts already prepared. TRA-A was observed to begin the process over again before she was interrupted by the surveyor. During interview on 4/26/17, at 1:57 p.m. TRA-A stated the donuts were made every fourth Wednesday of the month, their "donut day," when a band came to play for the residents and their families. She further stated the donut dough was made from scratch for the activities staff and contained raw eggs in it. TRA-A stated the activities staff before her did not use gloves and asked, "Am I suppose to?" TRA-A reported, "I'm only doing it the way the person prior to me did it," stating activities staff always made the donuts for donut day. She further stated,"I would suppose it would be an issue to touch the donuts after raw dough," reporting she should wear gloves so "you don't transfer the raw ingredients." During observation on 4/26/17, at 2:15 p.m. TRA-A was now observed wearing clear plastic gloves, however, she continued to pick up raw donuts, placed them in the two deep fryer baskets, turned them around in the fryer oil with tongs, and used the basket handle to pour the fried donuts into a metal bowel, and proceeded to pick up the ready to eat donuts to dip them in the sugar without changing gloves in between handling raw donut dough and ready to eat donuts. During interview on 4/26/17, at 2:15 p.m. TRA-A appeared confused stating she was doing the same process and touching raw dough, just with gloves on. TRA-A did not know how to fix the process. During the interview, at 2:21 p.m. the certified dietary manager (CDM) walked into the	21015	designee will be responsible for ongoing compliance. Date or Correction: June,6,2017	

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21015	Continued From page 21 kitchen and assisted TRA-A to find a metal spatula and new tongs to use, stating TRA-A needed to wash her hands and change her gloves in between touching raw dough and ready to eat donuts or use the utensils and not touch the dough at all. During interview on 4/26/17, at 2:38 p.m. the CDM stated activities puts on their donut day every month and was usually in care conferences all afternoon so she had not seen the activities staff make the donuts in the kitchen until that day. The CDM stated the activities staff only used the kitchen for donut day and TRA-A should have know that was not okay. The CDM reported the activities supervisor knew gloves were to be worn. The CDM stated ready to eat foods could not be touched with bare hands because of cross contamination and transferring the germs on your hands onto the food that is going to be eaten, stating she taught "if you are going to eat it don't touch it." The CDM further stated ready to eat food should not be touched after touching raw food, and even if wearing gloves cannot touch raw then cooked food, because there are raw eggs in the dough. During interview on 4/26/17, at 2:49 p.m. the therapeutic recreation director (TRD) stated the activity staff were in charge of making donuts and the staff were taught to wear gloves and a hairnet, but thought it was a bit hard to fry the donuts with the plastic gloves on due to the hot oil. The TRD stated everything else was pre-made for the activities except the donuts and she had not been aware of any issues with frying the donuts. A facility policy entitled Hand Washing And Glove Use, revised 4/26/17, directed, "Gloves may be	21015		

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21015	Continued From page 22 used when working with food to avoid contact with hands. Gloves must be worn when touching any ready-to-eat food." A facility policy entitled Temperatures And Safe Food Handling, undated, identified food-borne illnesses could be caused due to raw foods contaminating ready to eat or cooked foods. In addition, the policy directed to used tongs and not handle food with bare hands for proper food handling. SUGGESTED METHOD FOR CORRECTION: The administrator and the dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The certified dietary manager could monitor the service of food preparation on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21015		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications.	21545		6/6/17

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21545	Continued From page 23 B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 7 residents (R57, R43) medication was given with food as ordered/directed. This resulted in a facility medication error rate of 6.9 percent. Findings include:	21545	R57 & R43□s MAR & provider orders have been reviewed and are current. All residents that require special indications for taking their medications have had their MAR reviewed to assure special indications are addressed.	

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21545	Continued From page 24 R57's annual Minimum Data Set (MDS) dated 1/26/17, indicated R57 had severe cognitive impairment. The MDS included a diagnosis of gastroesophageal reflux disease and had a feeding tube. R57's Order Summary Report signed by the physician on 3/10/17, included an order to administer calcium carbonate suspension 1250 milligrams (mg)/ 5 milliliters (mL) by mouth (PO) or gastrostomy tube (g-tube) three times a day with meals. The summary also included a diagnosis of hypocalcemia. During observation on 4/25/17, at 11:08 a.m. licensed practical nurse (LPN)-B administered 5 ml of calcium carbonate suspension via R57's g-tube. Food was not provided at the time the medication was administered During interview on 4/25/17, at 11:22 a.m. LPN-B stated that the physician's orders in the electronic medication administration record (EMAR) directed staff to administer the calcium carbonate suspension three times a day with food. LPN-B further stated that by not administrating the medication as directed it could make R57 nauseated and the medication was administered too soon before lunch. During interview on 4/27/17, at 1:44 p.m. the director of nursing (DON) stated medications not given as directed were considered a medication error. The DON further stated that if a medication is ordered or directed to be given with food then the medication should be given with a meal or snack. The Drug Education Monograph dated 2017,	21545	The policy on Administering Medications was reviewed and is current. DON or designee[s] will conduct daily observational audits during med passes, on various shifts, documenting med administrations for residents that require meds taken with food daily for 7 days. Thereafter, audits will be conducted 3X weekly on various shifts for 2 weeks. If 100% compliance is achieved, random, observational audits will be continued monthly X90 days. The Nursing Department will be educated on Administering Medications, specifically administering medications to be given with food. Education will be completed for nursing staff responsible for administering medications on 5/22/2017 and 5/23/2017. Results of the random bi-weekly audits will be submitted monthly to the QA meeting for review and recommendations. Date of correction: June 6 , 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: _____ B. WING _____	C 04/27/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21545	Continued From page 25 directed calcium carbonate suspension be taken with meals. R43's admission MDS dated 11/09/16, indicated a diagnosis of gastroesophageal reflux disease R43's Order Summary Report signed by the physician on 3/3/17, indicated a diagnosis of hypokalemia and included an order to administer potassium chloride 30 milliequivalents (mEq) by mouth one time a day. The order included instructions that the potassium chloride was to be given with food. During observation on 4/26/17, at 7:10 a.m. LPN-C administered 30 mEq of potassium chloride by mouth to R43, however, food was not provided at the time the medication was administered. During interview on 4/26/2017, at 7:54 a.m. LPN-C stated that R43 was still in his room and that he had not gone to the dining room yet for breakfast. LPN-C reviewed the order in EMAR for potassium chloride and stated the dose was ordered as 30 mEq and that the instructions in EMAR indicate that this medication should be given with food. LPN-C stated that she had never noticed these instructions before. In addition, she stated her understanding of these instructions is that the medication should be given immediately prior to eating and that she would go and get him some toast right now. LPN-C then left the area and returned shortly after with toast for R43. The facility policy Medication Error and Adverse Drug Reaction Report dated 4/24/15, defined a medication error as, " An incorrect medication prescribed, dispensed, or administered to a	21545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21545	Continued From page 26 resident; an omission of a vital medication due to prescribing, dispensing, or administering error; medication administered to an individual with a documented allergy to the at medication." SUGGESTED METHOD OF CORRECTION: The facility administrator and director of nursing (DON) or designee could review facility policies and procedures, educate staff and implement an ongoing monitoring system to ensure all resident orders are correctly implemented as directed by physician orders. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21545		