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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5RL3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**
2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HENNING**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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

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

6. DATE OF SURVEY **03/31/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **42** (L18)
13.Total Certified Beds **42** (L17)

10.THE FACILITY IS CERTIFIED AS:
× 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
	42			
(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
Beth Nowling, HFE NEII
Date : 04/05/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 05/05/2016 (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
04/01/1990
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/30/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245540

May 5, 2016

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

Dear Ms. Gedde:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 21, 2016 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 5, 2016

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

RE: Project Number S5540026

Dear Ms. Gedde:

On March 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 10, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On March 31, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 24, 2016 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 February 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 10, 2016, effective March 21, 2016 and therefore remedies outlined in our letter to you dated March 1, 2016, 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 related to this letter.

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245540 Y1	A. Building B. Wing Y2	3/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0242	Correction	ID Prefix F0279	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0282	Correction	ID Prefix F0313	Correction	ID Prefix F0314	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(b)	Completed	Reg. # 483.25(c)	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0329	Correction	ID Prefix F0371	Correction	ID Prefix F0428	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.60(c)	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/21/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☐ xd	GL/mm	04/05/2016	34088	03/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/10/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245540 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/24/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	02/23/2016	LSC K0050	02/10/2016	LSC K0052	02/11/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0062	02/10/2016	LSC K0070	03/21/2016	LSC K0072	02/10/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0130	03/21/2016	LSC K0144	02/09/2016	LSC K0147	03/21/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0154	02/10/2016	LSC K0155	02/10/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	03/24/2016	34088	03/24/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/9/2016

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 5, 2016

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551
Re: Reinspection Results - Project Number S5540026

Dear Ms. Gedde:

On March 31, 2016 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 February 10, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00799 Y1	A. Building B. Wing Y2	3/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302	Correction	ID Prefix 20555	Correction	ID Prefix 20565	Correction
Reg. # MN State Statute 144.6503	Completed	Reg. # MN Rule 4658.0405 Subp. 1	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/21/2016
ID Prefix 20900	Correction	ID Prefix 21100	Correction	ID Prefix 21390	Correction
Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0650 Subp. 5	Completed	Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed
LSC	03/21/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix 21426	Correction	ID Prefix 21535	Correction	ID Prefix 21540	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule4658.1315 Subp.1 ABCD	Completed	Reg. # MN Rule 4658.1315 Subp. 2	Completed
LSC	03/31/2016	LSC	03/21/2016	LSC	03/21/2016
ID Prefix 21805	Correction	ID Prefix 21830	Correction	ID Prefix	Correction
Reg. # MN St. Statute 144.651 Subd. 5	Completed	Reg. # MN St. Statute 144.651 Subd. 10	Completed	Reg. #	Completed
LSC	03/21/2016	LSC	03/21/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	04/05/2016	34088	03/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/10/2016

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 13, 2016

Ms. Joan Gedde, Executive Director
Golden LivingCenter Henning
907 Marshall Avenue, P. O. Box 57
Henning, Minnesota 56551

Subject: Golden LivingCenter Henning - IDR
CMS Certification Number (CCN#): 24 5540
Project # S5540026

Dear Ms. Gedde:

This is in response to receipt dated March 4, 2015, of your request for an informal dispute resolution (IDR) for the federal deficiency identified at tag F314 issued pursuant to the survey event 5RL311, completed on February 10, 2016. The information presented with your letter, the CMS 2567 dated February 10, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

The information contained in written documentation presented by your facility for this IDR, the CMS 2567 dated February 10, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F314 S/S - G 42 CFR §483.25 (c) Pressure Ulcers: Based on a comprehensive assessment of a resident, that–
(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Summary of the facility's reason for IDR of this tag:

The facility indicates the requirements under 483.25(c) were met because they assert they had assessed, care planned and implemented care for this resident. The IDR request indicates the facility completed ongoing assessments appropriately, with frequent physician communication regarding the status of the resident and the pressure ulcer. The facility asserts they had assessed the pressure ulcer and revised the care plan appropriately. The facility also asserts the worsening of the resident's pressure ulcer was a result of co-morbid conditions and Prednisone (a corticosteroid medication) treatment. The facility requests the citation be removed or alternatively be changed to scope and severity level of F.

Summary of facts:

R37 was admitted to the facility on 8/6/15, and was assessed to have a Stage II area on the right buttock that measured 2.1 cm (centimeters) x 2.2 cm x 0.1 cm and a discolored area on the coccyx that measured 10 cm x 15 cm. The resident was placed on a side to side reposition schedule and provided with an alternating pressure air mattress. Because the resident was confined to bed upon admission, there were no care plan interventions developed for positioning the resident in a chair, nor assessment of chair sitting as it related to the resident's pressure ulcer. The care plan indicated the resident was to be turned and repositioned every two hours.

A progress note dated 9/3/15, indicated R37 could get up in a recliner wheelchair (w/c) once a shift every day and be left up for ½ hour. The note further indicated R37 was to be propped with pillows for positioning. There is no evidence the facility revised the resident's care plan at that time to indicate how long the resident could remain in a sitting position while she had a pressure ulcer. By 9/11/15, progress notes indicated the resident was sitting up in a chair for at least 90 minutes on one occasion. Progress notes continued to indicate R37 was up in the chair for up to 2.5 hours at a time. In addition, not all progress notes indicated the length of time she was up in the recliner chair. There was still no assessment conducted or care plan interventions developed to indicate how long R37 should have been up in the chair.

On 10/15/15, physician orders were received to start Prednisone. There was no indication the facility had considered this medication change as a possible reason to alter the resident's care plan related to her pressure ulcer until after the resident experienced a deterioration of the pressure ulcer.

Progress notes on 10/19/15, quoted the original therapy instructions to get R37 up in a recliner wheelchair once a shift every day for a half hour. The notes indicated the resident had complained of a "sore bottom" so would be left in bed and positioned side to side. There was no indication the resident's skin had been reassessed at that time, and on the following day 10/20/15, the resident was once again up in the wheelchair. Progress notes indicated R37's buttocks were "dark" and the medical director was notified. However there was no documented assessment or measurement of the area until 10/22/15, when it was identified as a shear/pressure wound measuring 6 cm x 9 cm x 0.1 cm and was pink in color.

The pressure ulcer continued to deteriorate over the next two months until the resident was sent to the hospital to have the area debrided on 12/16/15. After the ulcer was debrided, it was assessed as a Stage IV pressure ulcer. By the time of the survey in 2/16, as documented on the CMS 2567, the resident required a colostomy to divert stool from the rectum so a wound vac could be placed. The resident had a wound vac, was confined to bed, and was to be repositioned hourly from side to side. Surveyor observations and staff interview revealed the care plan was not implemented as written. The resident was not turned and repositioned for a period of almost three hours on 2/8/16.

A review of facility documents by the surveyor, and additional supervisory review to complete this IDR, revealed many weeks when the pressure ulcer was not assessed in order to determine if treatment was adequate or if the care plan required revision.

Summary of findings:

The facility failed to reassess and monitor the resident's pressure ulcer for an extended period of time after admission. They did not reassess in order to revise the care plan when new treatments were started such as sitting in a chair and the addition of a corticosteroid to her medication regimen. Although the facility had identified the addition of the corticosteroid could negatively impact wound healing, there was no indication there had been increased observation or assessment of the wound after the medication therapy was initiated. In addition, the facility did not immediately assess the resident's wound in an effort to determine whether the plan of care required revision even after R37 had complained of pain in the wound area.

After the resident was determined to have a Stage IV pressure ulcer, the facility did not always implement the plan of care as evidenced by the extensive period of time the resident was observed to be not repositioned on 2/8/16.

Non-compliance is based on the failure of the facility to reassess and monitor the pressure ulcer in a timely and consistent manner, failure to revise the care plan based on reassessment, and failure to implement the care plan as written.

As a result of this review, no modifications will be made to the details in the CMS 2567. The deficiency is valid as written and remains at a scope and severity of G, an isolated deficiency that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Health Regulation Divison
Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794 Fax: (651)201-3794

cc: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Maria King, Assistant Program Manager
Pam Kerssen, Assistant Program Manager
Gail Anderson, Fergus Falls Unit Supervisor
Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 5RL3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**

2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - HENNING**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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

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

6. DATE OF SURVEY **02/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **42** (L18)

13.Total Certified Beds **42** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(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 :
Denise Erickson, HFE NEII — 03/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 03/25/2016 (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
04/01/1990
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 1, 2016

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

RE: Project Number S5540026

Dear Ms. Gedde:

On February 10, 2016, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 March 21, 2016, 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 March 21, 2016 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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 10, 2016 (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 August 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

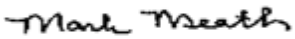
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

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

Sincerely,



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal dignity during leisure activities and meal service for 1 of 3 residents (R24) observed to utilize a gait belt for ambulation. Findings include: R24's quarterly Minimum Data Set (MDS) dated 11/18/15, identified R24 had moderate cognitive impairment, required extensive assistance from staff for personal hygiene, dressing, toileting and transferring.	F 241	It is the intent of Golden Living-Henning to treat our residents with dignity and respect. For (R24) education was provided immediately to nursing staff about appropriate use of gait belt and that it should not remain on a resident while at meals, leisure activities or while lying down. All residents have the potential to be affected by the deficient practice. Facility staff from all departments including managers have been educated	3/21/16

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

Electronically Signed | 03/10/2016

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F 241	Continued From page 1 R24's Care Area Assessment (CAA) dated 8/28/15, identified diagnoses which included cerebral vascular accident, blindness, depression, and hard of hearing. R24's current care plan revised 1/28/16, identified R24 had visual deficit due to blindness, hearing deficit and had physical impairments. R24's care plan listed various interventions which included staff assistance with ambulation with a gait belt and walker related to blindness, explain cares, encourage choices with cares, offer verbal cues and guidance. Observations on 2/8/16, identified the following: - At 3:55 p.m. R24 was assisted to walk by nursing assistant (NA)-E. R24 walked with a wheeled walker and wore a dark blue gait belt around his/her waist. -At 5:25 p.m. R24 was observed seated in a stationary chair, at a table in the dining room. The blue gait belt remained fastened around his/her waist. R24 had a brown cloth napkin/clothing protector on his/her chest, and cups of fluids with handles and straws were on the table in front of R24. -At 5:27 p.m. NA-E sat at the table to the right side of R24. NA-E offered R24 a drink and then explained coffee, chocolate milk and orange juice were available on the table in front of R24. -At 5:29 p.m. NA-E stood from the table and assisted other residents in the dining room with clothing protectors, drinks and meals. R24 remained seated at the table with the dark blue	F 241	on what dignity and respect is and how to treat residents with dignity and respect on March 3rd and March 8th. A make-up session will be held March 15th for any staff not able to attend the first two meetings. Weekly audits will be conducted on all shifts for four (4) weeks followed by every other week audits for four (4) weeks; with random audits conducted as deemed necessary thereafter. Audits will be conducted by DNS or designee. All findings will be reviewed monthly at QAPI. Corrective action to be completed by 3/21/2016.	

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F 241	Continued From page 2 gait belt fastened around his/her waist. - At 5:46 p.m. the facility Dietitian delivered R24's evening meal. -At 5:46 p.m. NA-A sat to the right side of R24 at the dining table. NA-A assisted R24 with eating, explaining where items were, handing utensils and bowls of foods to R24 and spooning foods directly into R24's mouth. The dark blue gait belt remained fastened around R24's waist throughout the evening meal service. -At 6:12 p.m. NA-A turned R24's stationary chair away from the table, placed the wheeled walker in front of R25 and assisted him/her to stand. NA-A guided R24 to walk through the dining room. NA-A did not grasp the gait belt to assist R24 to walk. NA-A instead held on to the front right side of R24's wheeled walker, and then the left front side of the walker until R24 had reached his/her room. -At 6:15 p.m. NA-A grasped the gait belt and assisted R24 into the bathroom without the use of the wheeled walker. -At 6:25 p.m. R24 was laying on his/her back in bed on top of the covers with three small blankets draped over R24's legs. R24 had head phones on listening to the television. The dark blue gait belt remained fastened around R24's waist. -At 7:07 p.m. the director of nursing (DON) assisted R24 to donn slippers, rise from the bed and walk down the hall towards the dining room for bingo. The DON walked R24 from his/her room down the hall with the gait belt which had remained fastened around R24's waist	F 241		

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F 241	Continued From page 3	F 241		

throughout the evening.

-At 7:15 p.m. R24 was seated at a table in the dining room between the bingo caller and a resident who was identified by R24 as a personal friend. The dark blue gait belt remained fastened around R24's waist throughout the observation of the bingo game which was completed at 7:51 p.m.

On 2/08/16, at 6:28 p.m. NA-A verified R24 had the gait belt on throughout the evening meal, and R24 currently continued to have the gait belt on while laying in bed. When questioned about the gait belt remaining fastened around R24's waist NA-A stated "[R24] will go down to bingo in a half hour." NA-A indicated that R24 did not always have the gait belt fastened around his/her waist. NA-A indicated at times R24 had been seated in the front lobby with a female resident and at that time the gait belt was loosened. NA-A stated "[R24] has never complained" about wearing the gait belt for extended periods of time.

Observations on 2/9/16, identified the following:

-At 2:54 p.m. NA-F assisted R24 to walk down the hall from his/her room to the dining room for cookies and coffee. NA-F seated R24 in a stationary chair and left the room. The dark blue gait belt remained fastened around R24's waist through the snack and visiting time.

-At 3:46 p.m. R24 was seated in the lobby in a stationary chair by the wall with a female resident. The dark blue gait belt remained around R24's waist.

On 2/09/16, at 10:45 a.m. NA-B identified R24

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F 241	Continued From page 4 utilized a gait belt to assist with walking and to provide safety. NA-B indicated R24 had not fallen while at the facility; however, had a knee that possibly may go out and R24 saw only shadows. NA-B identified it was not the usual facility practice to leave a gait belt fastened around a resident's waist when not walking with the resident. NA-B verified the gait belt should have been removed when R24 was seated in the dining room. On 2/09/16, at 12:50 p.m. the DON verified gait belts should be removed from around a resident's waist anytime when not walking. On 2/09/16, at 3:48 p.m. NA-G verified R24 had a gait belt on at this time while seated in the lobby visiting with a female resident. NA-G identified R24 utilized a gait belt for all transfers and walking. NA-G indicated gait belts were only fastened around R24's waist when being used and stated "I take it off when [R24] sits down, or is at the table." On 2/10/16, at 7:12 a.m. during interview, R24 indicated staff often applied the gait belt around R24's waist and it would remain in place all day. R24 stated staff had not asked if leaving the gait belt around R24's waist bothered [R24]." R24 stated "I probably look like hell, I can't see to take care of myself." The facility policy titled Transfer Activities, reviewed 1/26/15, directed staff with use of a gait belt; however, the policy did not address when the gait belt was to be removed.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		3/21/16

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F 242	Continued From page 5 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accommodate resident preferences for bathing for 2 of 2 residents (R30, R11) reviewed for bathing preferences. Findings include: R30 indicated on 2/07/16, at 4:29 p.m. he/she received a bath two times a week and stated "I really should have a bath every day" because of incontinence of loose stools. R30's quarterly Minimum Data Set (MDS) dated 1/18/16, identified R30 had intact cognition, required extensive assistance with transfers, mobility, toilet use, hygiene and dressing, and was frequently incontinent of bowel and bladder. The physician progress note dated 11/3/15, identified diagnoses which included incontinence, diarrhea, and colon cancer. Review of the facility bath schedule February 1 through February 9, noted R30 had received two baths a week, Thursday and Sunday. On 2/10/16, at 8:47 a.m. NA-D indicated R30 had intact memory, received a bath two times a week	F 242	F 242 It is the intent of Golden Living-Henning to honor all residents' right to self-determination (right to make choices). Residents #30 and #11 have been interviewed regarding bathing preferences, and are receiving baths per choice. All residents have the potential to be affected by the deficient practice. Current residents have been interviewed to determine bathing preference. Resident's bathing preferences are addressed upon admission and reviewed quarterly and as indicated. Residents are receiving baths per preferences. Bathing preferences are placed on a bathing sheet for CNA use daily. Staff has been educated on providing bathing per resident preferences to include any request for additional baths. Monitoring to ensure compliance, the DNS/designee will conduct random weekly audits/resident interviews that baths are being provided per resident preference. The results of the audits will be reviewed	

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F 242	Continued From page 6 on Sundays and Thursdays. NA-D identified if residents asked for additional baths staff tried to fulfill the request or would pass it on to the next shift. NA-D stated "[R30] tells me [he/she] wished [he/she] could have a bath every day,we try but most times can't." NA-D identified since the beginning of November staffing had been cut; however, R30 was not given more baths prior to having less staff scheduled. NA-D stated "We don't have time." R11 on 2/07/16, at 12:00 p.m. identified he/she received a bath once a week. R11 stated "I have told them I would like more and they said they have too many people." R11 indicated he/she had talked to a nurse and the bath aide to request more than one bath per week. R11's physician's progress note dated 11/24/15, identified diagnoses which included super-morbid obesity, limited mobility, peripheral neuropathy, chronic kidney disease and diabetes. R11's admission MDS assessment dated 11/27/15, identified R11 had intact cognition, and required extensive assistance with transfers, mobility, toilet use, hygiene and dressing, was frequently incontinent of bowel and bladder, and required total assistance with bathing. The nursing assistant care sheets identified R11 was frequently incontinent of bowel and bladder and received a bath on Wednesdays. Review of the bath schedule February 1 through February 9, noted R11 had received one bath a week, on Wednesday. On 2/09/16, at 10:55 a.m. NA-B identified R11 was unable to go into the bathroom to wash.	F 242	monthly in QAPI.	

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F 242	Continued From page 7 NA-B indicated R11 was given a wash cloth and a towel to wash daily and received a tub bath one time a week. On 2/10/16, at 8:31 a.m. The licensed social worker (LSW)-F identified she did not coordinate resident bathing schedules. LSW-F indicated the nurses scheduled bathing and reviewed preferences. LSW-F identified her involvement with bathing was to inquire resident preferences of tub baths versus showers and how important the choice is to the resident, for documentation on the MDS. On 2/10/16, at 11:33 a.m. the assistant director of nursing (ADON) identified a bathing schedule was initiated upon admission to the facility; however, if a resident voiced a request for more baths staff would try to accommodate the request. The ADON indicated being unaware R30 or R11 had made requests for more baths. On 2/10/16, at 1:55 p.m. the director of nursing (DON) identified each resident received one bath or shower per week unless they had incontinence issues or a request for more baths or showers. The DON stated "If a resident requests more, we make every effort to accommodate them." The Don verified the usual facility practice was to honor resident requests. The requested facility policy was not provided.	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		3/21/16

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F 279	Continued From page 8 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to include appropriate interventions to assist in hearing for 1 of 1 residents (R24) reviewed for hearing. Findings include: R24's quarterly Minimum Data Set (MDS) dated 11/18/15, identified R24 had moderate cognitive impairment, ability to hear with hearing aid normally used with moderate difficulty, and required speaker to increase volume and speak distinctly, required extensive assistance from staff for personal hygiene, and dressing. The Care Area Assessment (CAA) dated 8/28/15, identified diagnoses which included cerebral vascular accident, blindness, depression, and hard of	F 279	F 279 It is the intent of Golden Living-Henning to have to have a comprehensive care plan for each resident. (R 24) care plan has been reviewed and revised as indicated regarding the use of hearing aids per resident's personal preference. Two additional residents have the potential to be affected by the deficient practice. Resident care plans have been reviewed and revised as indicated that interventions to assist with hearing are in place. Staff has been educated on updating care plans with hearing and vision interventions. Monitoring to ensure compliance, the	

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F 279	Continued From page 9 hearing. R24's current care plan revised 1/28/16, identified R24 had blindness, impaired communication due to impaired hearing, preferred to wear only one hearing aid and directed staff to ensure hearing aid was in place and functioning; however, did not specify staff to direct conversation to the ear with the hearing aid in place. During the initial interview on 2/7/16, at 4:08 p.m. R24 was asked if staff included him/her in decisions about your medicine, therapy, or other treatments? R24 stated,"They don't tell me much of anything. I think they whisper sometimes, they don't want me to know what they are talking about." During the evening meal on 2/08/16, from 5:46 p.m. to 6:12 p.m. R24 was observed to have a hearing aid in the left ear. Nursing assistant (NA)-A was seated on the right side of R24. NA-A handed R24 an eating utensil and explained where R24's food items were placed on the table. R24 did not voice a response to NA-A, and R24 did not make an effort to feed self. NA-A stated "Is your hearing aid working?" and then handed R24 a bowl of soup. R24 accepted the bowl, held it up to his/her mouth and spooned soup into his/her mouth. NA-A was observed repeatedly cueing R24 to eat, speaking to the ear that did not have the hearing aid throughout the meal. On 2/09/16, at 8:47 a.m. licensed practical nurse (LPN)-B approached R24 with medications in a white paper cup. LPN-B spoke in to R24's right ear and placed the medicine cup in R24's hand. LPN-B asked R24 while speaking in to his/her	F 279	DNS/designee will conduct random weekly audits of care plans compared to direct care observation that care planned interventions are in place The results of the audits will be reviewed at the QAPI meeting monthly. Corrective action will be completed by 3/21/2016.	

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F 279	Continued From page 10	F 279		

right ear if something more to drink was needed. R24 did not respond the first time the question was asked and with repeated questioning from staff appeared to become agitated. R24 shook his/her head from side to side and responded with a stern "no."

On 2/09/16, at 2:54 p.m. NA-F assisted R24 to walk down the from R24's room to the dining room for coffee and cookies. NA-F walked on R24's right side talking to the ear without the hearing aid.

On 2/08/16, at 6:28 p.m. NA-A verified R24 only wore one hearing aid, but was not aware which ear R24 wore the hearing aid in. NA-A agreed R24 would be able to hear better out of the ear with the hearing aid. NA-A confirmed he/she had utilized R24's right ear, without the hearing aide to attempt to communicate with R24. NA-A confirmed R24's left ear had not been used to attempt to communicate and stated "I didn't think of it."

On 2/09/16, at 10:45 a.m. NA-B indicated although R24 did have a hearing aid for both ears, R24 was able to hear better with the left ear and R24 chose to wear the hearing aid only in the left ear.

On 2/10/16, at 7:12 a.m. R24 identified he/she wore only one hearing aid and was able to hear adequately if it was quiet and the speaker spoke loudly. R24 stated "They should know I hear with the ear with the hearing aid. The other ear is no good."

On 2/10/16, at 1:55 p.m. the director of nursing (DON) verified she would expect staff to speak

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F 279	Continued From page 11 into the ear which R24 wore the hearing aid. The DON indicated R24's preference for wearing the hearing aid and need to use the hearing aid appropriately should should have been communicated to the staff in order for staff to be aware of how to talk to R24. The requested facility policy regarding care planing was not provided.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care plan interventions for positioning for 1 of 2 residents (R37) reviewed for pressure ulcers. Findings include: Review of R37's care plan dated 8/24/15, identified R37 had a current pressure ulcer. R37's care plan identified R37 required assistance of 2 staff to turn and reposition every 1-2 hours. R37's care plan listed various interventions of a pressure relieving mattress and to complete weekly wound assessments on R37's pressure ulcer.	F 282	F 282 It is the intent of Golden Living-Henning to provide cares per care plan by appropriately trained staff. Resident #37 care plan has been reviewed and revised as indicated related to turning and repositioning, and care is being provided per care plan. Complete tissue tolerance observation for current residents to determine positioning needs and care plan as appropriate. Residents are receiving care per care plan for repositioning. Staff has been educated on providing care for residents per care plan. Monitoring to ensure compliance, the DNS/designee will conduct random	3/21/16

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F 282	Continued From page 12 On 2/8/16, during continuous observations from 3:56 p.m. to 6:26 p.m., R37 was observed lying in bed on her right side without being offered, or assisted to reposition during the entire observation. - At 3:56 p.m. R37 was lying on her right side in bed with an air alternating mattress in place. R37 had a book in her hands, eyes were open and the room lights were on. - At 4:15 p.m. R37 remained on her right side in bed, had set her book on the bed and closed her eyes. No staff were observed to offer assistance. - At 5:10 p.m. R37 remained lying in bed on her right side. The social worker (SW) was observed to enter R37's room and spoke briefly with R37. R37 opened her eyes and nodded. The SW then left the room, R37 closed her eyes and remained on her right side. - At 5:24 p.m. R37 remained lying in bed on her right side, covers up to mid torso. Nursing assistant (NA)-A walked down the hallway, past R37's room. NA-A did not offer R37 assistant with repositioning. R37 remained on her right side lying in bed. - At 5:35 p.m. registered nurse (RN)-B walked into R37's room, assisted to empty R37's colostomy bag while R37 remained on her right side. RN-B administered R37's medications and fluid flushes via gastric tube (g-tube.) RN-B hooked up R37's tube feeding and raised R37's head of bed. RN-B was not observed to offer R37 repositioning. RN-B left R37's room at 5:44 p.m., R37 remained on her right side.	F 282	weekly audits/direct care observations that cares that re-positioning is being provided per care plan. The results of the audits will be reviewed in QAPI.	

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F 282	Continued From page 13	F 282		

- At 6:20 p.m. R37 remained lying in bed on her right side with eyes closed and a blanket covered up to her torso. No staff was observed to offer assistance with repositioning.

- At 6:26 p.m. RN-B and the director of nursing (DON) entered R37's room. RN-B and the DON lifted R37's body with a lift sheet and R37 towards the DON. R37 was assisted to turn to her left side, facing RN-B. R37 had a blue incontinent pad unattached, under her buttocks which stuck to R37's buttocks when she was turned by the DON and RN-B. R37's skin was damp/moist from the bottom of the hair on her head to the bottom of her thighs. R37's pillow case, fitted, lift and top sheets were also damp/moist. The DON peeled the blue incontinent pad away from R37's buttocks skin and pulled a layer of granulation tissue from two 1 cm x 1 cm circular open area's on the right edge of R37's right buttocks and upper right thigh. The DON stated she felt these areas were from adhesive tape which was no longer in use. R37's entire sacrum was covered with a transparent dressing which held a black wound vacuum sponge (wound vac) in place. A plastic tube was observed from under the transparent dressing and was attached to a suction device with a canister which collected drainage from R37's stage 4 pressure ulcer. R37's skin was dark purple/ red in color with linen creases on her entire right side (from the shoulder to the bottom of her thigh.) The DON stated she felt R37's skin had creases imprinted from the linen, was damp from sweat and had blanchable redness on her right side shoulder, buttocks, hip and thigh. The DON confirmed R37 had a current stage 4 sacral pressure ulcer and indicated R37 was on a every hour side to side repositioning program. The DON and RN-B

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F 282	Continued From page 14	F 282		

assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels.

On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not to lay on her back and was bedridden due to the stage 4 pressure ulcer on her sacrum. The DON stated she was unsure why R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes.

On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed on R37's right side.

On 2/8/16, at 7:10 p.m. nursing assistant (NA)-E stated she had last repositioned R37 around 3:30 p.m. NA-E stated she understood R37 was on a every 2 hour repositioning schedule and stated she was unaware R37 was supposed to be repositioned every hour.

On 2/8/16, at 7:43 p.m. NA-A stated he had not assisted R37 to reposition since about 3:30 p.m. and stated R37 was supposed to be repositioned

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F 282	Continued From page 15 every 1-2 hours. NA-A stated staff were unable to assist R37 with repositioning because other residents had needed assistance. R37 had not been repositioned from 3:30 p.m. to 6:26 p.m. a total of 2 hours and 56 minutes. Review of the facility policy titled Clinical Health Status, Additional Assessments and Immediate Plan of Care (IPOC) with a review date of 5/3/15, indicated an resident assessment was to be completed. In addition, if any blue shaded boxes were checked on the Clinical Health Status it indicated the need for IPOC related to the section.	F 282		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary services related to the use of a hearing device appropriately for 1 of 1 residents (R24) reviewed for hearing. Findings include:	F 313	F 313 It is the intent of Golden Living-Henning to ensure residents have appropriate treatments/devices to meet vision and hearing needs. Resident #24 is receiving assistance for hearing loss per personal preference.	3/21/16

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F 313	Continued From page 16 R24's quarterly Minimum Data Set (MDS) dated 11/18/15, identified R24 had moderate cognitive impairment, ability to hear with hearing aid normally used with moderate difficulty, and required speaker to increase volume and speak distinctly, required extensive assistance from staff for personal hygiene, and dressing. The Care Area Assessment (CAA) dated 8/28/15, identified diagnoses which included cerebral vascular accident, blindness, depression, and hard of hearing. R24's current care plan revised 1/28/16, identified R24 had blindness, impaired communication due to impaired hearing, preferred to wear only one hearing aid and directed staff to ensure hearing aid was in place and functioning; however, did not specify staff to direct conversation to the ear with the hearing aid in place. During the initial interview on 2/7/16, at 4:08 p.m. R24 was asked if staff included him/her in decisions about your medicine, therapy, or other treatments? R24 stated,"They don't tell me much of anything. I think they whisper sometimes, they don't want me to know what they are talking about." During the evening meal on 2/08/16, from 5:46 p.m. to 6:12 p.m. R24 was observed to have a hearing aid in the left ear. Nursing assistant (NA)-A was seated on the right side of R24. NA-A handed R24 an eating utensil and explained where R24's food items were placed on the table. R24 did not voice a response to NA-A, and R24 did not make an effort to feed self. NA-A stated "Is your hearing aid working?" and then handed	F 313	All other residents identified as needing assistance with vision and hearing, are receiving assistance per care plan and personal preference. Staff has been educated on providing care to residents related to hearing and vision, based on care plan and personal preference. Care plans and CNA care sheets have been updated to reflect individualized needs of the residents. Monitoring to ensure compliance, the DNS/designee will conduct random weekly audits/care observations that interventions are in place for vision and hearing. The results of the audits will be reviewed at the QAPI meeting monthly.	

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F 313	Continued From page 17	F 313		

R24 a bowl of soup. R24 accepted the bowl, held it up to his/her mouth and spooned soup into his/her mouth. NA-A was observed repeatedly cueing R24 to eat, speaking to the ear that did not have the hearing aid throughout the meal.

On 2/09/16, at 8:47 a.m. licensed practical nurse (LPN)-B approached R24 with medications in a white paper cup. LPN-B spoke in to R24's right ear and placed the medicine cup in R24's hand. LPN-B asked R24 while speaking in to his/her right ear if something more to drink was needed. R24 did not respond the first time the question was asked and with repeated questioning from staff appeared to become agitated. R24 shook his/her head from side to side and responded with a stern "no."

On 2/09/16, at 2:54 p.m. NA-F assisted R24 to walk down the from R24's room to the dining room for coffee and cookies. NA-F walked on R24's right side talking to the ear without the hearing aid.

On 2/08/16, at 6:28 p.m. NA-A verified R24 only wore one hearing aid, but was not aware which ear R24 wore the hearing aid in. NA-A agreed R24 would be able to hear better out of the ear with the hearing aid. NA-A confirmed he/she had utilized R24's right ear, without the hearing aide to attempt to communicate with R24. NA-A confirmed R24's left ear had not been used to attempt to communicate and stated "I didn't think of it."

On 2/09/16, at 10:45 a.m. NA-B indicated although R24 did have a hearing aid for both ears, R24 was able to hear better with the left ear and R24 chose to wear the hearing aid only in

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F 313	Continued From page 18 the left ear. On 2/10/16, at 7:12 a.m. R24 identified he/she wore only one hearing aid and was able to hear adequately if it was quiet and the speaker spoke loudly. R24 stated "They should know I hear with the ear with the hearing aid. The other ear is no good." On 2/10/16, at 1:55 p.m. the director of nursing (DON) verified she would expect staff to speak into the ear which R24 wore the hearing aid. The DON indicated R24's preference for wearing the hearing aid and need to use the hearing aid appropriately should should have been communicated to the staff in order for staff to be aware of how to talk to R24. The requested facility policy regarding care planing was not provided.	F 313		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 314	F 314	3/21/16

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F 314	Continued From page 19 review, the facility failed to comprehensively assess and failed to conduct ongoing monitoring of a worsening pressure ulcer for 1 of 2 residents (R37) reviewed for pressure ulcers. In addition, the facility failed to implement repositioning interventions for 1 of 2 residents (R37) reviewed for pressure ulcers. This deficient practice resulted in actual harm for R37, who had a stage 2 pressure ulcer worsen to a stage 4 pressure ulcer. Findings include: Review of R37's quarterly Minimum Data Set (MDS) dated 1/25/16, identified R37 had severe cognitive impairment and had diagnoses which included: encephalopathy, dysphagia and pressure ulcers. The MDS identified R37 was totally dependent upon staff for all activities of daily living (ADL's.) The MDS identified R37 had a stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer which measured 8.0 centimeters (cm) long, 7.0 cm wide and 4.2 cm deep. The MDS identified R37's stage 4 pressure ulcer had worsened since the previous assessment. The MDS listed pressure ulcer interventions which included: pressure ulcer care, dressing changes, pressure relieving device for bed and a turning and repositioning program. Review of R37's admission MDS dated 8/13/15, identified R37 had severe cognitive impairment and had diagnoses which included: encephalopathy, dysphagia and pressure ulcers. The MDS identified R37 was totally dependent on staff for all ADL's. The MDS identified R37 had a	F 314	It is the intent of Golden Living-Henning to ensure appropriate treatment to prevent pressure ulcers and to treat or seek medical appointments for pressure ulcers that are acquired prior to admission. Resident #37 care plan, assessments, treatments, and documentation of wounds have been reviewed and updated. No other residents with pressure ulcers at this time. Other resident identified with skin integrity at risk; care plans, assessments, treatments and documentation have been reviewed and updated. The living center has reviewed and revised the Skin Integrity Program including skin assessments, care plan interventions, treatments, and documentation of Skin Integrity. Licensed and non-licensed staff has been educated on the revised Skin Integrity Program. Monitoring to ensure compliance, the DNS/designee will conduct random weekly audits/direct care observations that care is being provided per care plan, documentation, and assessments are being completed per living center Skin Integrity Guideline. The results of the audits will be reviewed at the QAPI meeting monthly.	

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stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister) pressure ulcer. The MDS listed pressure ulcer interventions included: pressure ulcer care and a pressure relieving device for bed.

Review of R37's pressure ulcer Care Area Assessment (CAA) dated 8/13/15, identified R37 had a stage 2 pressure ulcer. The CAA identified R37 was at risk for pressure ulcer development and required physical assistance with bed mobility and repositioning.

Review of R37's care plan dated 8/24/15, identified R37 had a current pressure ulcer. R37's care plan identified R37 required assistance of 2 staff to turn and reposition every 1-2 hours. R37's care plan listed various interventions of a pressure relieving mattress and to complete weekly wound assessments on R37's pressure ulcer.

On 2/8/16, during continuous observations from 3:56 p.m. to 6:26 p.m., R37 was observed lying in bed on her right side without being offered, or assisted to reposition during the entire observation.

- At 3:56 p.m. R37 was lying on her right side in bed with an air alternating mattress in place. R37 had a book in her hands, eyes were open and the room lights were on.

- At 4:15 p.m. R37 remained on her right side in bed, had set her book on the bed and closed her eyes. No staff were observed to offer assistance.

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- At 5:10 p.m. R37 remained lying in bed on her right side. The social worker (SW) was observed to enter R37's room and spoke briefly with R37. R37 opened her eyes and nodded. The SW then left the room, R37 closed her eyes and remained on her right side.

- At 5:24 p.m. R37 remained lying in bed on her right side, covers up to mid torso. Nursing assistant (NA)-A walked down the hallway, past R37's room. NA-A did not offer R37 assistant with repositioning. R37 remained on her right side lying in bed.

- At 5:35 p.m. registered nurse (RN)-B walked into R37's room, assisted to empty R37's colostomy bag while R37 remained on her right side. RN-B administered R37's medications and fluid flushes via gastric tube (g-tube.) RN-B hooked up R37's tube feeding and raised R37's head of bed. RN-B was not observed to offer R37 repositioning. RN-B left R37's room at 5:44 p.m., R37 remained on her right side.

- At 6:20 p.m. R37 remained lying in bed on her right side with eyes closed and a blanket covered up to her torso. No staff was observed to offer assistance with repositioning.

- At 6:26 p.m. RN-B and the director of nursing (DON) entered R37's room. RN-B and the DON lifted R37's body with a lift sheet and R37 towards the DON. R37 was assisted to turn to her left side, facing RN-B. R37 had a blue incontinent pad unattached, under her buttocks which stuck to R37's buttocks when she was turned by the DON and RN-B. R37's skin was damp/moist from the bottom of the hair on her head to the

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bottom of her thighs. R37's pillow case, fitted, lift and top sheets were also damp/moist. The DON peeled the blue incontinent pad away from R37's buttocks skin and pulled a layer of granulation tissue from two 1 cm x 1 cm circular open area's on the right edge of R37's right buttocks and upper right thigh. The DON stated she felt these areas were from adhesive tape which was no longer in use. R37's entire sacrum was covered with a transparent dressing which held a black wound vacuum sponge (wound vac) in place. A plastic tube was observed from under the transparent dressing and was attached to a suction device with a canister which collected drainage from R37's stage 4 pressure ulcer. R37's skin was dark purple/ red in color with linen creases on her entire right side (from the shoulder to the bottom of her thigh.) The DON stated she felt R37's skin had creases imprinted from the linen, was damp from sweat and had blanchable redness on her right side shoulder, buttocks, hip and thigh. The DON confirmed R37 had a current stage 4 sacral pressure ulcer and indicated R37 was on a every hour side to side repositioning program. The DON and RN-B assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels.

On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not to lay on her back and was bedridden due to the stage 4 pressure ulcer on her sacrum. The DON stated she was unsure why R37 was not

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repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes.

On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated R37's wound was currently being routinely evaluated by a CWON. The ADON stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed on R37's right side. ADON stated she was the person who was responsible for completion of the weekly wound assessments for R37. ADON stated R37 had been admitted with a stage 2 pressure ulcer on her sacrum and had been on a turn and repositioning program of every 2 hours. ADON stated R37's physician had evaluated R37's stage 2 pressure ulcer and identified R37 needed surgical debridement of the pressure ulcer. ADON stated R37 had a surgical debridement of the stage 2 pressure ulcer on 12/15 which had revealed R37 had a stage 4 pressure ulcer on her sacrum. ADON stated R37 required a diverting colostomy (a surgical procedure which diverts stool from the rectum to a opening in the abdomen which then empties stool into a bag,) so a wound vac could be placed to R37's stage 4 sacral pressure ulcer. ADON indicated R37 had two pressure ulcer assessments in August and was unable to provide any further assessments in the electronic medical record (EMR) until December 2015. ADON confirmed there were no weekly wound assessments in R37's EMR from 8/16/15 to 12/15 for R37's pressure ulcer which

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worsened from a stage 2 pressure ulcer to a stage 4 pressure ulcer.

On 2/8/16, at 7:10 p.m. nursing assistant (NA)-E stated she had last repositioned R37 around 3:30 p.m. NA-E stated she understood R37 was on a every 2 hour repositioning schedule and stated she was unaware R37 was supposed to be repositioned every hour.

On 2/8/16, at 7:43 p.m. NA-A stated he had not assisted R37 to reposition since about 3:30 p.m. and stated R37 was supposed to be repositioned every 1-2 hours. NA-A stated staff were unable to assist R37 with repositioning because other residents had needed assistance.

R37 had not been repositioned from 3:30 p.m. to 6:26 p.m. a total of 2 hours and 56 minutes.

On 2/10/16, at 7:36 a.m. observations of R37's pressure ulcer care was conducted with CWON and ADON present in R37's room. A wound vac machine was observed attached by tubing to R37's stage 4 sacral pressure ulcer. The drainage collection cartridge of the wound vac contained reddish black drainage. ADON and CWON verified R37's drainage was reddish black and foul smelling. After the transparent dressing from R37's sacrum was removed, CWON stated R37 had a increased area of pressure on the left edge of the current pressure ulcer. CWON identified R37 had necrotic tissue which extended 2 cm from the opening of the sacral ulcer and was present from a 9 o'clock position to the 11 o'clock position of the wound. CWON stated she felt R37 had been laying on one side too long and had caused pressure. CWON stated 0.5 cm x 1.0 cm of R37's sacral bone was visible at the

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F 314	Continued From page 25 12-1 o'clock position. CWON stated R37's sacral wound had tunneling present from 9 o'clock to 3 o'clock. CWON stated R37's stage 4 sacral pressure ulcer measured 5.5 cm long x 6 cm wide and was 3.5 cm deep. CWON indicated R37 had superficial open areas from adhesive tape on her right buttocks and thigh both were 2 cm in diameter. She also stated she had re-educated staff after the transparent dressings used with the wound vac had been applied incorrectly and caused the new open areas on the buttocks. CWON stated R37 also had two 2 cm diameter blisters, one on each shoulder from shearing due to the lift sheet being kept under R37. The CWON stated R37's shearing areas were noted in early February and a different lift sheet had been ordered but had not arrived in facility at present. Review of R37's weekly wound assessments from 8/6/15, to 12/24/15, revealed the following: -On 8/6/15, identified R37 had been admitted to the facility with a stage 2 pressure ulcer on the buttocks. The assessment revealed R37's stage 2 pressure ulcer measured 2.1 cm x 2.2 cm x 0.1 cm and had 100% epithelial tissue present. The assessment identified current interventions of a pressure redistribution mattress and barrier cream to the ulcer every shift. -On 8/19/15, revealed R37's stage 2 pressure ulcer measured 2.1 cm x 2.1 cm x 0.1 cm and had 100% epithelial (definition)tissue present. The assessment identified current interventions of a pressure redistribution mattress, barrier cream and a turn and repositioning program of every 2 hours.	F 314		

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F 314	Continued From page 26 -On 12/24/15, identified R37 had a stage 4 sacral pressure ulcer. The assessment revealed R37's was admitted with a pressure ulcer which had become worse and required hospitalization for a surgical debridement of the sacral pressure ulcer. The assessment revealed R37's stage 4 pressure ulcer measured 8.2 cm x 8.6 cm x 5.1 cm, was red with 75% granulation (new vascular tissue in granular form on an ulcer or the healing surface of a wound) tissue, 25% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed,)tissue and had a moderate amount of serosanguineous (yellowish serum with small amounts of blood) drainage. The assessment revealed the skin surrounding R37's pressure ulcer was macerated/soft and the margins were undefined. The assessment further revealed no tunneling or odor were present. The assessment identified current interventions of a pressure redistribution mattress, turn and repositioning program of every 2 hours side to side, not to sit in a wheelchair and treatment of saline soaked kerlix (gauze packing) and cover with ABD (thick absorbent dressing,) and directed staff not to use tape on R37's skin at pressure ulcer site. The assessment revealed a wound vac was to be placed the following week following a diverting colostomy (diverts the bowel to an opening in the abdomen where a stoma is created.) -On 1/7/16, revealed R37's stage 4 sacral pressure ulcer measured 9.2 cm x 10 cm x 5.2 cm, had undermining on the right side of the wound from 1 o'clock to 3 o'clock, had a moderate amount of serosanguineous drainage	F 314		

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and no odor. The assessment revealed R37's pressure ulcer had 70% granulation and 30% slough tissue, surrounding skin was reddish and macerated. The assessment identified current interventions of wet to dry kerlix, cover with ABD and a plan to place a wound vac that week.

-On 1/28/16, revealed R37's stage 4 sacral pressure ulcer measured 7 cm x 6 cm x 4.2 cm, had undermining on the top edges, had a moderate amount of serosanguineous drainage which had a strong odor. The assessment revealed R37's pressure ulcer had 50% granulation and 50% slough tissue, surrounding skin was macerated. The assessment identified current interventions of a wound vac changed on Monday, Wednesday, Friday, air mattress, side to side positioning and CWON or primary care provider (PCP) to monitor weekly.

-On 2/1/16, revealed R37's stage 4 sacral pressure ulcer measured 6.3 cm x 7.1 cm x 3.6 cm, had a large amount of serosanguineous drainage which had a strong odor. The assessment revealed R37's pressure ulcer had 50% slough and 50% granulation tissue margins were maceration. The assessment identified current interventions of wound vac, pressure redistribution mattress, specific turn and reposition program and heel boots. The assessment lacked mention of R37's surrounding skin and whether undermining continued to be present.

-On 2/3/16, revealed R37's stage 4 sacral pressure ulcer measured 7 cm x 7 cm x 5 cm, had a moderate amount of serosanguineous drainage with no odor. The assessment revealed

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R37's pressure ulcer had 75% granulation tissue (did not identify the other 25% of tissue present,) had undefined, macerated margins and had maceration on the surrounding skin. The assessment revealed two areas of maceration from the transparent dressing adhesive pulling on R37's skin. The assessment identified current intervention of a wound vac, pressure redistribution mattress, wheel chair cushion, specific turn and repositioning program, positioning devices, heel boots. The assessment lacked the presence of undermining.

R37's clinical record lacked documentation of wound assessments completed of R37's pressure ulcer from 8/19/15, to 12/24/15, a total of 4 months.

Review of R37's clinical health status form dated 8/6/15, identified R37 had a 2 cm x 2.5 cm open area on the buttocks and an area of chaffed, denuded skin which measured 10 cm x 15 cm on the buttocks. The form identified R37's Braden scale (a scale used to predict risk for pressure sore development based on moisture, activity, mobility, nutrition, sensory, friction and shear,) score placed R37 at high risk for pressure ulcers.

Review of R37's clinical health status form dated 12/24/15, identified R37 had a stage 4 sacral pressure ulcer and continued to be at high risk for developing pressure ulcers.

Review of R37's tissue tolerance test (TTT, a test which measures tissue tolerance for sitting and lying) dated 8/10/15, revealed R37 had normal skin over bony prominences after 2 hours of lying. The assessment revealed R37 was at high risk for developing pressure ulcers.

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Review of R37's TTT dated 12/28/15, identified R37 was able to tolerate 1.5 hours of lying without redness or signs of breakdown. The assessment revealed R37 had an order not to sit upright and was at severe risk for pressure ulcers.

Review of R37's physician and CWON progress notes from 10/22/15, to 1/16, revealed the following;

-On 10/22/15, CWON note identified R37 had three wounds which required assessment. The note identified R37 had wound on the buttocks related to shear/pressure, measured 6 cm x 9 cm x 0.1 cm and was pink with a 0.5 cm dark area in center. The note identified R37 had a wound on the lateral side of the right heel, pressure non-blanchable, measured 1 cm x 1 cm.. The note further identified R37 had a wound on the lateral left heel, pressure, non-blanchable, measured 1.5 cm x 1 cm. The note directed staff off load heels at all times, and to cleanse buttocks wound with normal saline and apply a large foam dressing windowed with transparent dressing and change every 3 days and as needed. The note directed to follow up with her as needed.

-On 10/28/16, MD note identified R37 had a fairly large skin ulcer on the buttocks, decubitus ulcer.

-On 12/01/15, MD note revealed R37's sacral wound was not assessed at the time of the visit.

-On 12/15/15, MD note revealed R37's sacral ulcer was assessed and the wound was gaping open and looked like a stage 4 ulcer. The note further revealed MD's plan was to have CWON

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assess R37's sacral ulcer the following day.

-On 12/16/15, MD history and physical note revealed R37 had a sacral decubitus ulcer which had increased in size. The note revealed R37 had been seen at the facility on 12/15/15, the sacral ulcer had deteriorated and there was complete penetration of the skin and subcutaneous tissue in the ulcer. The note revealed there had been significant drainage and evidence of necrotic tissue. The note identified R37 had a stage 4 pressure ulcer with complete penetration of the subcutaneous tissue and a plan to have the ulcer surgically debrided that day.

R37's record revealed R37 had been hospitalized from 12/30/15 to 1/6/16 for surgery for a diverting colostomy in order to place a would vac for treatment of the stage 4 pressure ulcer.

-On 1/8/16, CWON note identified R37's sacral pressure ulcer measured 9 cm x 9 cm x 4 cm, had undermining at 11 o'clock of 3 cm. The note identified R37's pressure ulcer had 75% red wound base and some slough with a black area from 7-12 o'clock, moderate amount of serous drainage, no odor and had a 1 cm area of black of the wound edge at 11 o'clock.

-On 1/14/16, CWON note identified R37's sacral pressure ulcer measured 8 cm x 7 cm x 5 cm with a 2 cm x 3 cm dry necrotic area of the wound edge at 4 o'clock. The note identified R37's pressure ulcer had 75% beefy red wound base with some adherent yellow slough.

-On 2/3/16, CWON note identified R37 had 5 areas of concern. The note revealed R37's stage 4 sacral pressure ulcer measured 7 cm x 7 cm x

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5 cm, had pink fascia (a thin sheath of fibrous tissue enclosing a muscle or other organ,) moderate serous drainage. The note identified R37 had an area in the right gluteal crease from shearing which measured 1.4 cm x 3 cm x 0.1 cm. The note revealed R37 had a sheared area on the left buttocks which measured 2.8 cm x 1 cm. The note revealed R37 had a pressure area on the left scapula which measured 4 cm x 10 cm and was described as a blanchable redness. The note further revealed R37 had a pressure area on the right scapula which measured 3 cm x 4 cm and was also described as a blanchable redness and had an intact blister 1 cm x 2 cm blister. The note identified R37 was to be assisted with repositioning every hour by staff and to observe for reddened areas and to obtain a turning sheet.

On 2/9/16, at 2:28 p.m. during a phone interview the medical doctor (MD), he stated he felt R37's sacral pressure ulcer had likely always been a stage 4 ulcer as the edges of the wound had become suspicious. The MD stated he would expect facility staff to monitor R37's pressure ulcer weekly including measurements and tissue type. The MD also stated he would expect the facility staff to routinely reposition R37 from side to side. The MD also stated R37's pressure ulcer had started out as a small pressure ulcer, though wasn't straight forward with its appearance. The MD stated once the pressure ulcer was surgically debrided it was determined to be a stage 4.

On 2/10/16, at 8:26 a.m. CWON verified R37 had a stage 4 pressure ulcer to her sacrum. CWON stated she felt R37's pressure ulcer had likely started out as an unstageable pressure ulcer and was able to be staged after the surgical debridement. CWON stated R37 should be

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repositioned every 1 hour side to side. CWON stated she had recommended R37 be repositioned side to side hourly once R37 sides of her body had began to get red. CWON also stated R37 needed a different type of lift sheet due to the blisters and abrasions which had been ordered.

On 2/10/16, at 9:01 a.m. during a follow up interview the DON stated they were unable to provide any comprehensive wound assessments for R37 from 8/19/15, to 12/24/15, and stated she were not sure what happened. The DON stated she expected R37's pressure ulcer to be assessed weekly and monitored daily. The DON stated she expected R37's care plan to be followed and recommendations from the CWON to be followed to aid in healing R37's pressure ulcer.

On 2/10/16, at 3:13 p.m. the ADON provided hand written copies of documentation of wound monitoring for 16 dates between 9/7/15 and 12/21/5 which the ADON confirmed she had just recreated from random notes on her personal calendar and from post it notes which she had found in her office. The ADON stated the re-created assessments were not complete assessments, but she had written information on a wound evaluation flow sheet for the dates and measurements of the wound from the post notes and notes on her calendar.

A facility policy for pressure ulcer prevention and treatment was requested and not provided.

The facility provided a copy of the form CMS (centers for Medicare and Medicaid services) 2012 (7/20/15), titled Positioning Critical Element

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F 314	Continued From page 33 Pathway, which is a pathway for investigation of positioning needs for residents in long term care facility. Review of the facility policy titled Pressure ulcers, nutritional services, reviewed 12/16/15, revealed the dietitian would be responsible for longing monitoring and documentation of resident status of nutritional needs with the presence of a pressure ulcer.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		3/21/16

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F 329	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed monitor the ongoing effectiveness of an antidepressant (Celexa) medication for 1 of 5 residents (R30) utilized for obsessive compulsive disorder. Findings include: R30's quarterly Minimum Data Set (MDS) dated 1/18/16, identified R30 was cognitively intact and had no behaviors, hallucinations or delusions during the assessment period. R30's current care plan revised 5/16, directed care which included: diabetes, activities, oral care, and physical functioning, however, did not address the use of Celexa related to obsessive compulisive disorder and monitoring of those beahviors. R30's current medication orders signed by the physician 1/14/16, identified R30 received Celexa 20 milligrams (mg) daily for the diagnoses of OCD (obsessive compulsive disorder)/anxiety with start date of 11/18/15. Review of R30's physican note dated 11/3/15, revealed R30 had been started on Celexa 10mg daily for OCD/anxiety for delusions of greens worms and obsessive thoughts of cleaning her jewelry which seemed to occupy her thoughts and time. Review of R30 phsycian note dated 11/17/15, revealed R30's dose of Celexa had been increased to 20 mg daily for continued delusions	F 329	F 329 It is the intent of Golden Living-Henning to have all residents free of unnecessary drugs. Resident #30 medication regimen has been reviewed by the Consultant Pharmacist. Resident #30 care plan has been reviewed and revised as indicated regarding unnecessary medication. Other residents reviewed by Pharmacy Consultant and none found to have unnecessary drugs. Monitoring to ensure compliance, the DNS/designee will conduct random weekly audits of care plan, charts, and eMAR for medication regimen. The results of the audits will be reviewed at the QAPI meeting monthly.	

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F 329	Continued From page 35 and hallucinations. Review of R30's clinical record, 11/19/15 through 2/2/16 and review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) January and February, lacked documentation of monitoring of the effect of Celexa related to behaviors for the diagnosis of OCD. On 2/10/16, at 11:08 a.m. the assistant director of nursing (ADON) verified R30 currently received Celexa 20 mg daily for the diagnosis of OCD behaviors with a start date of 11/18/15. The ADON verified the current care plan did not address R30's use of Celexa for OCD behaviors. The ADON indicated with orders of Celexa for OCD staff had been expected to enter specific target behaviors and side effects of the medications into the MAR and the TAR. The ADON identified the nurses would then review and document every shift if the behaviors or side effects were present and if so, would write a progress note explaining the specifics of the behavior and/or side effects. On 2/10/16, at 1:55 p.m. the director of nursing (DON) indicated R30's care plan should have included the use of Celexa, with target behaviors and interventions. The DON verified documentation should have been completed for monitoring of side effects. The requested facility policy was not provided.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371		3/21/16

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F 371	Continued From page 36 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure open food items in the kitchen's refrigerator and the resident's refrigerator located in the north dining room were sealed and dated when opened. This had the potential to affect 23 of 24 residents who resided in the facility. Findings Include: On 2/7/16, at 9:08 a.m. the tour of the kitchen revealed the middle refrigerator had a package of cheddar cheese in it with masking tape loosely around the package opening (but not sealing the package), and the cheese was not dated when it was opened. Cook (C-A) verified the package of cheese was not sealed, and there was no open date on the package. C-A stated the cheese should be placed in a plastic container with a lid on it, and it should be dated. On 2/7/16, at 1:50 p.m. the refrigerator in the north dining room contained a pealed orange in a zip lock bag with one section of 2 slices that had a circular black spot in the center of it approximately 0.25 centimeters (cm) in size. In addition, in the same bag there was a 1/2 orange	F 371	F 371 It is the intent of Golden Living-Henning to ensure residents are served food that has been stored, prepared, and served in a sanitary manner. The refrigerator and freezer have been cleaned. Items in the refrigerator and freezer are dated and stored per policy. Staff has been educated on cleaning, storing, and dating food stored in the refrigerator/freezer. Monitoring to ensure compliance, the ED/designee will conduct random weekly audits of the refrigerator/freezer. The results of the audits will be reviewed at the monthly QAPI meeting.	

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F 371	Continued From page 37 which had 3 dark circular areas on it; one area approximately 0.5 cm in size, one slightly smaller then 0.5 cm and the 3rd area was pinpoint in size. There was a resident's first name on the bag, but it was not dated. The refrigerator also contained a brown pie box with a resident's first name and last initial on it. The use date on the box was 12/28/15. The pie box contained 4 slices of pie. In addition, there was a quart of eggnog that had not been opened but had an expiration date of 1/6/16. At 2:10 p.m. registered nurse (RN-A) stated the refrigerator in the north dining room is used for the residents and their families. RN-A stated the oranges had mold on them and belonged to a resident that was no longer residing in the facility. RN-A verified the blueberry pie had a use by date of 12/28/15, and it should have been thrown away. RN-A stated the usual facility practice was for housekeeping or maintenance to check the refrigerator daily and if the food is old or expired they would throw it away. RN-A stated if housekeeping or maintenance have concerns about the food or if they find outdated food in the refrigerator they would throw it away and would tell nursing. RN-A stated they should be checking the refrigerator daily and confirmed the food items were available for the residents in the north dining room and were outdated. On 2/9/16, at 3:15 p.m. the dietitian (D)-D stated the expired blueberry pie, oranges with the dark spots and eggnog findings were not acceptable. D-D verified the food should have open dates on them and the moldy oranges discarded. D-D stated the dining department was to check daily for outdated food and open dates on food, and it had not been done daily. D-D stated they should be labeling and dating food items and checking that food is not spoiled or has not expired daily.	F 371		

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F 371	Continued From page 38 D-D stated the cook should check for expiration dates, labels and open dates on the food package. The daily cleaning schedule indicated the a.m. and p.m. cook was to remove outdated food items. Review of the facility January cleaning schedule from 1/4/16, to 1/31/16, identified the a.m. cook had not checked for outdated food items 16 out of 27 days and the p.m. cook had not checked for outdated food items 8 out of 27 days. Review of the February cleaning schedule from 2/1/16, to 2/9/16, identified the a.m. cook had not checked for outdated items 3 out of 9 days and the p.m. cook had not checked 1 out of 9 days. The facility policy titled Storage of Refrigerated Foods reviewed 2/12/15, had indicated to monitor all items daily for expiration dates or use by dates and discard all outdated items daily.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 428	F 428	3/21/16

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F 428	Continued From page 39 facility consulting pharmacist failed to identify the irregularity for 1 of 1 residents (R30) who lacked ongoing monitoring of the effectiveness of an antidepressant (Celexa) medication ordered to treat obsessive compulsive disorder. Findings include: R30's quarterly Minimum Data Set (MDS) dated 1/18/16, identified R30 was cognitively intact and had no behaviors, hallucinations or delusions during the assessment period. R30's current care plan revised 5/16, directed care which included: diabetes, activities, oral care, and physical functioning, however, did not address the use of Celexa related to obsessive compulsive disorder and monitoring of those behaviors. R30's current medication orders signed by the physician 1/14/16, identified R30 received Celexa 20 milligrams (mg) daily for the diagnoses of OCD (obsessive compulsive disorder)/anxiety with start date of 11/18/15. Review of R30's physician note dated 11/3/15, revealed R30 had been started on Celexa 10mg daily for OCD/anxiety for delusions of greens worms and obsessive thoughts of cleaning her jewelry which seemed to occupy her thoughts and time. Review of R30 physician note dated 11/17/15, revealed R30's dose of Celexa had been increased to 20 mg daily for continued delusions and hallucinations. Review of R30's clinical record, 11/19/15 through	F 428	It is the intent of Golden Living-Henning to ensure medication regimens are reviewed monthly for all residents. Resident #30 medication regimen has been reviewed by the Consultant Pharmacist. Resident #30 care plan has been reviewed and revised as indicated regarding psychological diagnosis and medications. Resident care plans have been reviewed and revised as indicated for residents with psychological diagnosis including residents with anti-depressant use. Staff has been educated on updating care plans with psychological diagnosis. Staff also educated on documenting benefits, no change, or adverse side effects of this medication. Other residents identified as having a new psychotropic medication will have care plans updated and documentation regarding benefits, no change, or adverse side effects. Pharmacy consultant will conduct monthly audits of all resident charts. Behavioral health meeting with IDT will audit random charts each week for documentation regarding benefits, no change, or adverse effects of medications as well as reduction trials. The results will be reviewed at QAPI meeting monthly.	

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F 428	Continued From page 40 2/2/16 and review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) January and February, lacked documentation of monitoring of the effect of Celexa related to behaviors for the diagnosis of OCD. Review of R30's progress notes from 11/16/15 to 2/10/16 revealed the following pharmacy notes: -12/8/15, resident placed on citalopram (Celexa), dose increased to 20 mg 11/15 to help manage anxiety, appears to tolerate. Will continue to monitor. -1/15/16, no recommendations On 2/10/16, at 11:08 a.m. the assistant director of nursing (ADON) verified R30 currently received Celexa 20 mg daily for the diagnosis of OCD behaviors with a start date of 11/18/15. The ADON verified the current care plan did not address R30's use of Celexa for OCD behaviors. The ADON indicated with orders of Celexa for OCD staff had been expected to enter specific target behaviors and side effects of the medications into the MAR and the TAR. The ADON identified the nurses would then review and document every shift if the behaviors or side effects were present and if so, would write a progress note explaining the specifics of the behavior and/or side effects. On 2/10/16, at 1:55 p.m. the director of nursing (DON) indicated R30's care plan should have included the use of Celexa, with target behaviors and interventions. The DON verified documentation should have been completed for monitoring of side effects.	F 428		

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F 428	Continued From page 41 On 2/10/16 at 2:55 p.m. a call was placed to the consulting pharmacist for interview and message was left. No return call was received during or immediately after survey. The requested facility policy was not provided.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		3/21/16

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F 441	Continued From page 42 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi- use supply container was maintained in a sanitary manner. This had the potential to effect 2 of 2 residents (R11, R30) who currently utilized a shared container of items to monitor blood glucose. Findings include: On 2/07/16, at 12:03 p.m. registered nurse (RN)-B entered R11's room with a plastic container of glucometer supplies. The container had no cover and the sides of the container had the appearance of woven plastic strips with small open areas on all four sides. RN-B placed the container directly on to the top of R11's over-the-bed table. With gloved hands, RN-B removed an alcohol wipe, lancet and glucose strip from the container. Following the use of these items to check R11's blood glucose, RN-B carried the container to the bathroom with the same gloved hands, and placed the container on the top of the toilet tank. RN-B removed the soiled gloves, turned on the water faucet, and found no running water at this time. RN-B picked up the container of blood glucose supplies, carried it back to the medication cart and placed it	F 441	F 441 It is the intent of Golden Living-Henning to ensure resident safety by infection control measures. Residents #11 and #30 are receiving glucometer checks in a sanitary manner. Other residents requiring glucometer checks reviewed and are receiving checks in a sanitary manner. Licensed staff has been educated on providing glucometer checks in a sanitary manner. Monitoring to ensure compliance, DNS/designee will conduct random weekly audits of glucometer checks. The results of the audits will be reviewed at QAPI meeting monthly.	

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F 441	Continued From page 43	F 441		

directly on the top of the medication cart. RN-B disposed of the used lancet and blood glucose strip into a sharps container, and sanitized the glucometer with a germicidal bleach wipe. RN-A began to place the container into the top drawer of the medication cart with other resident medication items and was stopped by the surveyor.

On 2/07/16, at 12:20 p.m. RN-B verified he/she had attempted to place the container into the top drawer of the medication cart without sanitizing the bottom of the container. RN-B identified it was not the usual facility practice to place multi-use containers onto unclean surfaces nor was it usual practice to return an item to the medication cart without sanitizing it. RN-B indicated the multi-use container should have been placed onto a paper towel on the over-the-bed table, and should not have been placed on top of the toilet tank. RN-B further indicated the bin should have been sanitized with a germicidal bleach wipe before placing it onto the top of the medication cart and returning it to the drawer.

On 2/10/16, at 1:55 p.m. the director of nursing (DON) verified the container became contaminated when placed on top of the resident's over-the-bed table and the toilet tank, and agreed the multi-use container should have been sanitized before returning it to the medication cart. The DON identified the expectation that the container of supplies would remain in the medication cart. The DON stated "the supply basket should never leave the med [medication] cart."

The facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, reviewed

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	245540	A. BUILDING _____ B. WING _____	02/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - HENNING	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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F 441	Continued From page 44 11/11/15, identified the resident care equipment would be cleaned and disinfected according to the CDC (Centers for Disease Control) recommendations. The CDC web page Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, identified "The ultimate goal of the Recommendations for Disinfection and Sterilization in Health-Care Facilities, 2008, is to reduce rates of health-care-associated infections through appropriate use of both disinfection and sterilization."	F 441		

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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, Golden Livingcenter - Henning 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us or 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 Golden Livingcenter - Henning is a 1-story building with out a basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II (111) construction. In 1963 an addition was constructed to the north of the original building, is 1-story, without a basement and Type II (111). In 1988, an addition was constructed to the south that was determined to be of Type II (000) construction which is not separated from the original building. The building is protected throughout by an automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire	K 000		

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K 000	Continued From page 2 Alarm Code" 1999 edition. The facility has a capacity of 42 beds and had a census of 23 at time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide smoke resistant corridor walls that meet the requirements of NFPA 101 (00), sections 19.3.6.2.2 and 19.3.6.4. This deficient practice could affect any residents using the dining room (a separate smoke compartment) and an undetermined amount of staff and visitors. Findings include	K 017	Insulate penetrations with fiberglass and seal louvers closed with fire Barrier sealant; project to be completed by Maintenance Dir. Completion Date : 2/23/2016	2/23/16

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K 017	Continued From page 3 On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 observations revealed louvers at 3 locations in the lower level corridor walls within the location of the maintenance office entrance. These findings were observed by the facility Maintenance Manager.	K 017		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire which would affect all 23 residents, staff and visitors Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 documentation review revealed the fire drill for November of 2015 was missed. This deficient practice was verified by the Maintenance Manager	K 050	Follow NFPA requirements for Conducting Fire Drills. Begin using new form that also requires signature of Executive Director. Completion Date: 2/10/2016	2/10/16

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K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all 23 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 documentation review revealed that there was no record of sensitivity tests of the smoke alarms. This deficient practice was verified by the Maintenance Manager	K 052	Summit to conduct sensitivity test. This test will now be conducted annually and documented in the Life Safety Binder. Maintenance Dir. to monitor that test is completed annually. Completion Date: 2/11/2016	2/11/16
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		2/10/16

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K 062	Continued From page 5 Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 23 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 documentation review revealed that the last sprinkler flow test was in October of 2015. This deficient practice was verified by the Maintenance Manager	K 062	Follow NFPA requirements for conducting fire sprinkler flow test. Life Safety Binder to reflect documentation. Added to the computerized maintenance system to generate a work order quarterly. Maintenance Dir. to monitor to ensure test is completed regularly. Completion Date: 2/10/2016	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on obervation and staff interview it was revealed that the facility failed to meet the requirements for portable space heating devices as per 2000 NFPA 101 section 19.7.8. This deficient practice could cause a fire and affect the 13 resident rooms in the North wing and an undetermined amount of staff and visitors.	K 070	Remove heater from resident room #34. Educate staff that portable space heaters are not allowed in resident rooms. Maint. Dir. and ED to observe during regular environmental tours that portable space heaters are not used in resident rooms. Completion Date: 3/21/2016	3/21/16

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K 070	Continued From page 6 On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 observations revealed that a portable space heater was being used in resident room #34 This deficient practice was verified by the Maintenance Manager	K 070		
K 072 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observations the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.10. This deficient practice could interfere with the convenient and effective removal of the room resident, and any staff or visitor in an emergency situation,. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 observations revealed that in resident rooms 17, 5, and 7 the bathroom door and the main room door, due to hardware mounted on the tops of each door, collide when both are opened to a 45 degree and would bind and not allow the entrance door to fully open. This deficient practice was verified by the	K 072	Maint. Dir. to remove the parts of the hardware colliding and verify entrance door will open with out obstruction. Audit other doors for this potential and remove hardware colliding. Completion Date: 2/10/2016	2/10/16

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K 072	Continued From page 7 Maintenance Manager	K 072		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to meet the requirements of NFPA 99 (99) section 7-5.1.2.6 and S&C 14-46-LSC for the proper use of power tap strips. This deficient practice could affect 10 of the 23 residents and an undetermined amount of visitors in case of an electrical fire. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 observations revealed that in resident room 34 the battery of a power chair was being charged through the use of a power tap. This deficient practice was verified by the Maintenance Manager	K 130	The charger for the power chair battery was removed from the power tap. Staff to be educated regarding what is allowed to be plugged into a power tap. Maint. Dir. and ED to observe during regular environmental tours that power taps are used appropriately. Completion Date: 3/21/16	3/21/16
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all 23 residents and an undetermined amount of staff and visitors. Findings include:	K 144	Maint. Dir. to add a column to the generator test form to log the generator cool down. Completion Date: 2/9/2016	2/9/16

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K 144	Continued From page 8 On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 documentation review revealed that the generator cool down was not being logged. This deficient practice was verified by the Maintenance Manager	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and an email recieved by the MDH surveryors it was revealed that the facility failed to maintain the facilitys electrical wiring per NFPA 101 (99) section 9.1.2 and NFPA 70. This deficient practice could affet all 23 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 observations and through an email from the MDH surveyors, it was revealed that an electric outlet was worn to a point that the TV plug was taped to hold it in place and the power tap used to compensate the worn outlet also had a loose fit. This deficient practice was verified by the Maintenance Manager	K 147	Replace worn outlet. Maint. Dir. to complete audit of electrical outlets in resident rooms for any needing replacing. Staff to be educated that taping of electrical outlet to hold in place in not allowed. Maint. Dir. to continue inspection verifying all outlets comply using the computerized preventative maintenance program to issue work orders. Completion Date: 3/21/2016	3/21/16
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire	K 154		2/10/16

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K 154	Continued From page 9 watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 23 residents and an undetermined amount of visitors and staff. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 review of the documentation revealed there was not a proper policy for the Fire Sprinkler Out of Service. This deficient practice was verified by the Maintenance Manager.	K 154	Maint. Dir. to modify current policy to meet expectations of a separate proper policy. Print and insert in Life Safety Binder. Completion Date: 2/10 /2016	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire alarm system has to be placed out-of-service for	K 155	Maint. Dir. to modify current policy to meet expectations of a separate proper policy. Print and insert in Life Safety Binder. Completion Date: 2/10/2016	2/10/16

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K 155	Continued From page 10 four or more hours in a 24 hour period. NFPA 101 (00) section 19.7. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 23 residents, visitors and staff. Findings include: On the facility tour between 8:30 am to 12:00 pm on 02/9/2016 review of the documentation revealed there was not a proper policy for the Fire Alarm System Out of Service. This deficient practice was verified by the Maintenance Manager.	K 155		

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically deliverred
March 1, 2016

Ms. Joan Gedde, Administrator
Golden LivingCenter - Henning
907 Marshall Avenue, PO Box 57
Henning, Minnesota 56551

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5540026

Dear Ms. Gedde:

The above facility was surveyed on February 7, 2016 through February 10, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Gail Anderson at (218) 332-8140 or email: gail.anderson@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00799	A. BUILDING: _____ B. WING _____	02/10/2016

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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: The facility has 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	2 000		

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2 000	Continued From page 1 Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 302	Continued From page 2	2 302		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease and dementia training, including a description of the training program, the categories of employees trained, the frequency of training and the basic	2 302	Corrected	3/21/16

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2 302	Continued From page 3 topics covered in the training in a written or electronic form. In addition the facility could not provide documentation of Alzheimer's education provided to the facility staff. Findings include: No documentation was found to include information regarding staff training of Alzheimer's disease and dementia as required, including review of the facility admission packet. During an interview on 2/10/16, at 4:30 p.m., the director of nursing (DON) verified she was unable to locate Alzheimer's education, training dates, who attended the training and the information the facility was to provide to consumers with the required information regarding Alzheimer's training. The DON indicated she was not aware of the requirement. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet for consumer information. The DON or designee could educate staff and conduct audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident	2 555		3/21/16

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2 555	Continued From page 4 assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a care plan to include appropriate interventions to assist in hearing for 1 of 1 residents (R24) reviewed for hearing. Findings include: R24's quarterly Minimum Data Set (MDS) dated 11/18/15, identified R24 had moderate cognitive impairment, ability to hear with hearing aid normally used with moderate difficulty, and required speaker to increase volume and speak distinctly, required extensive assistance from staff for personal hygiene, and dressing. The Care Area Assessment (CAA) dated 8/28/15, identified diagnoses which included cerebral vascular accident, blindness, depression, and hard of hearing. R24's current care plan revised 1/28/16, identified R24 had blindness, impaired communication due to impaired hearing, preferred to wear only one hearing aid and directed staff to ensure hearing aid was in place and functioning; however, did not specify staff to direct conversation to the ear with the hearing aid	2 555	Corrected	

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2 555	Continued From page 5 in place. During the initial interview on 2/7/16, at 4:08 p.m. R24 was asked if staff included him/her in decisions about your medicine, therapy, or other treatments? R24 stated,"They don't tell me much of anything. I think they whisper sometimes, they don't want me to know what they are talking about." During the evening meal on 2/08/16, from 5:46 p.m. to 6:12 p.m. R24 was observed to have a hearing aid in the left ear. Nursing assistant (NA)-A was seated on the right side of R24. NA-A handed R24 an eating utensil and explained where R24's food items were placed on the table. R24 did not voice a response to NA-A, and R24 did not make an effort to feed self. NA-A stated "Is your hearing aid working?" and then handed R24 a bowl of soup. R24 accepted the bowl, held it up to his/her mouth and spooned soup into his/her mouth. NA-A was observed repeatedly cueing R24 to eat, speaking to the ear that did not have the hearing aid throughout the meal. On 2/09/16, at 8:47 a.m. licensed practical nurse (LPN)-B approached R24 with medications in a white paper cup. LPN-B spoke in to R24's right ear and placed the medicine cup in R24's hand. LPN-B asked R24 while speaking in to his/her right ear if something more to drink was needed. R24 did not respond the first time the question was asked and with repeated questioning from staff appeared to become agitated. R24 shook his/her head from side to side and responded with a stern "no." On 2/09/16, at 2:54 p.m. NA-F assisted R24 to walk down the from R24's room to the dining room for coffee and cookies. NA-F walked on	2 555		

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2 555	Continued From page 6 R24's right side talking to the ear without the hearing aid. On 2/08/16, at 6:28 p.m. NA-A verified R24 only wore one hearing aid, but was not aware which ear R24 wore the hearing aid in. NA-A agreed R24 would be able to hear better out of the ear with the hearing aid. NA-A confirmed he/she had utilized R24's right ear, without the hearing aide to attempt to communicate with R24. NA-A confirmed R24's left ear had not been used to attempt to communicate and stated "I didn't think of it." On 2/09/16, at 10:45 a.m. NA-B indicated although R24 did have a hearing aid for both ears, R24 was able to hear better with the left ear and R24 chose to wear the hearing aid only in the left ear. On 2/10/16, at 7:12 a.m. R24 identified he/she wore only one hearing aid and was able to hear adequately if it was quiet and the speaker spoke loudly. R24 stated "They should know I hear with the ear with the hearing aid. The other ear is no good." On 2/10/16, at 1:55 p.m. the director of nursing (DON) verified she would expect staff to speak into the ear which R24 wore the hearing aid. The DON indicated R24's preference for wearing the hearing aid and need to use the hearing aid appropriately should should have been communicated to the staff in order for staff to be aware of how to talk to R24. The requested facility policy regarding care planing was not provided.	2 555		

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2 555	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures to ensure the development of care plans. The director of nursing or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement care plan interventions for positioning for 1 of 2 residents (R37) reviewed for pressure ulcers. Findings include: Review of R37's care plan dated 8/24/15, identified R37 had a current pressure ulcer. R37's care plan identified R37 required assistance of 2 staff to turn and reposition every 1-2 hours. R37's care plan listed various interventions of a pressure relieving mattress and to complete weekly wound assessments on R37's pressure ulcer.	2 565	Corrected	3/21/16

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2 565	Continued From page 8 On 2/8/16, during continuous observations from 3:56 p.m. to 6:26 p.m., R37 was observed lying in bed on her right side without being offered, or assisted to reposition during the entire observation. - At 3:56 p.m. R37 was lying on her right side in bed with an air alternating mattress in place. R37 had a book in her hands, eyes were open and the room lights were on. - At 4:15 p.m. R37 remained on her right side in bed, had set her book on the bed and closed her eyes. No staff were observed to offer assistance. - At 5:10 p.m. R37 remained lying in bed on her right side. The social worker (SW) was observed to enter R37's room and spoke briefly with R37. R37 opened her eyes and nodded. The SW then left the room, R37 closed her eyes and remained on her right side. - At 5:24 p.m. R37 remained lying in bed on her right side, covers up to mid torso. Nursing assistant (NA)-A walked down the hallway, past R37's room. NA-A did not offer R37 assistant with repositioning. R37 remained on her right side lying in bed. - At 5:35 p.m. registered nurse (RN)-B walked into R37's room, assisted to empty R37's colostomy bag while R37 remained on her right side. RN-B administered R37's medications and fluid flushes via gastric tube (g-tube.) RN-B hooked up R37's tube feeding and raised R37's head of bed. RN-B was not observed to offer R37 repositioning. RN-B left R37's room at 5:44 p.m., R37 remained on her right side.	2 565		

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2 565	Continued From page 9 - At 6:20 p.m. R37 remained lying in bed on her right side with eyes closed and a blanket covered up to her torso. No staff was observed to offer assistance with repositioning. - At 6:26 p.m. RN-B and the director of nursing (DON) entered R37's room. RN-B and the DON lifted R37's body with a lift sheet and R37 towards the DON. R37 was assisted to turn to her left side, facing RN-B. R37 had a blue incontinent pad unattached, under her buttocks which stuck to R37's buttocks when she was turned by the DON and RN-B. R37's skin was damp/moist from the bottom of the hair on her head to the bottom of her thighs. R37's pillow case, fitted, lift and top sheets were also damp/moist. The DON peeled the blue incontinent pad away from R37's buttocks skin and pulled a layer of granulation tissue from two 1 cm x 1 cm circular open area's on the right edge of R37's right buttocks and upper right thigh. The DON stated she felt these areas were from adhesive tape which was no longer in use. R37's entire sacrum was covered with a transparent dressing which held a black wound vacuum sponge (wound vac) in place. A plastic tube was observed from under the transparent dressing and was attached to a suction device with a canister which collected drainage from R37's stage 4 pressure ulcer. R37's skin was dark purple/ red in color with linen creases on her entire right side (from the shoulder to the bottom of her thigh.) The DON stated she felt R37's skin had creases imprinted from the linen, was damp from sweat and had blanchable redness on her right side shoulder, buttocks, hip and thigh. The DON confirmed R37 had a current stage 4 sacral pressure ulcer and indicated R37 was on a every hour side to side repositioning program. The DON and RN-B	2 565		

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2 565	Continued From page 10	2 565		

assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels.

On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not to lay on her back and was bedridden due to the stage 4 pressure ulcer on her sacrum. The DON stated she was unsure why R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes.

On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed on R37's right side.

On 2/8/16, at 7:10 p.m. nursing assistant (NA)-E stated she had last repositioned R37 around 3:30 p.m. NA-E stated she understood R37 was on a every 2 hour repositioning schedule and stated she was unaware R37 was supposed to be repositioned every hour.

On 2/8/16, at 7:43 p.m. NA-A stated he had not assisted R37 to reposition since about 3:30 p.m. and stated R37 was supposed to be repositioned every 1-2 hours. NA-A stated staff were unable to

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2 565	Continued From page 11 assist R37 with repositioning because other residents had needed assistance. R37 had not been repositioned from 3:30 p.m. to 6:26 p.m. a total of 2 hours and 56 minutes. Review of the facility policy titled Clinical Health Status, Additional Assessments and Immediate Plan of Care (IPOC) with a review date of 5/3/15, indicated an resident assessment was to be completed. In addition, if any blue shaded boxes were checked on the Clinical Health Status it indicated the need for IPOC related to the section. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures to ensure care plans were being implemented. The director of nursing or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR 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	2 900		3/21/16

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2 900	Continued From page 12 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 comprehensively assess and failed to conduct ongoing monitoring of a worsening pressure ulcer for 1 of 2 residents (R37) reviewed for pressure ulcers. In addition, the facility failed to implement repositioning interventions for 1 of 2 residents (R37) reviewed for pressure ulcers. This deficient practice resulted in actual harm for R37, who had a stage 2 pressure ulcer worsen to a stage 4 pressure ulcer. Findings include: Review of R37's quarterly Minimum Data Set (MDS) dated 1/25/16, identified R37 had severe cognitive impairment and had diagnoses which included: encephalopathy, dysphagia and pressure ulcers. The MDS identified R37 was totally dependent upon staff for all activities of daily living (ADL's.) The MDS identified R37 had a stage 4 (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer which measured 8.0 centimeters (cm) long, 7.0 cm wide and 4.2 cm deep. The MDS identified R37's stage 4 pressure ulcer had	2 900	Corrected	

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2 900	Continued From page 13 worsened since the previous assessment. The MDS listed pressure ulcer interventions which included: pressure ulcer care, dressing changes, pressure relieving device for bed and a turning and repositioning program. Review of R37's admission MDS dated 8/13/15, identified R37 had severe cognitive impairment and had diagnoses which included: encephalopathy, dysphagia and pressure ulcers. The MDS identified R37 was totally dependent on staff for all ADL's. The MDS identified R37 had a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister) pressure ulcer. The MDS listed pressure ulcer interventions included: pressure ulcer care and a pressure relieving device for bed. Review of R37's pressure ulcer Care Area Assessment (CAA) dated 8/13/15, identified R37 had a stage 2 pressure ulcer. The CAA identified R37 was at risk for pressure ulcer development and required physical assistance with bed mobility and repositioning. Review of R37's care plan dated 8/24/15, identified R37 had a current pressure ulcer. R37's care plan identified R37 required assistance of 2 staff to turn and reposition every 1-2 hours. R37's care plan listed various interventions of a pressure relieving mattress and to complete weekly wound assessments on R37's pressure ulcer. On 2/8/16, during continuous observations from 3:56 p.m. to 6:26 p.m., R37 was observed lying in bed on her right side without being offered, or	2 900		

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2 900	Continued From page 14 assisted to reposition during the entire observation. - At 3:56 p.m. R37 was lying on her right side in bed with an air alternating mattress in place. R37 had a book in her hands, eyes were open and the room lights were on. - At 4:15 p.m. R37 remained on her right side in bed, had set her book on the bed and closed her eyes. No staff were observed to offer assistance. - At 5:10 p.m. R37 remained lying in bed on her right side. The social worker (SW) was observed to enter R37's room and spoke briefly with R37. R37 opened her eyes and nodded. The SW then left the room, R37 closed her eyes and remained on her right side. - At 5:24 p.m. R37 remained lying in bed on her right side, covers up to mid torso. Nursing assistant (NA)-A walked down the hallway, past R37's room. NA-A did not offer R37 assistant with repositioning. R37 remained on her right side lying in bed. - At 5:35 p.m. registered nurse (RN)-B walked into R37's room, assisted to empty R37's colostomy bag while R37 remained on her right side. RN-B administered R37's medications and fluid flushes via gastric tube (g-tube.) RN-B hooked up R37's tube feeding and raised R37's head of bed. RN-B was not observed to offer R37 repositioning. RN-B left R37's room at 5:44 p.m., R37 remained on her right side. - At 6:20 p.m. R37 remained lying in bed on her right side with eyes closed and a blanket covered up to her torso. No staff was observed to offer assistance with repositioning.	2 900		

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2 900	Continued From page 15 - At 6:26 p.m. RN-B and the director of nursing (DON) entered R37's room. RN-B and the DON lifted R37's body with a lift sheet and R37 towards the DON. R37 was assisted to turn to her left side, facing RN-B. R37 had a blue incontinent pad unattached, under her buttocks which stuck to R37's buttocks when she was turned by the DON and RN-B. R37's skin was damp/moist from the bottom of the hair on her head to the bottom of her thighs. R37's pillow case, fitted, lift and top sheets were also damp/moist. The DON peeled the blue incontinent pad away from R37's buttocks skin and pulled a layer of granulation tissue from two 1 cm x 1 cm circular open area's on the right edge of R37's right buttocks and upper right thigh. The DON stated she felt these areas were from adhesive tape which was no longer in use. R37's entire sacrum was covered with a transparent dressing which held a black wound vacuum sponge (wound vac) in place. A plastic tube was observed from under the transparent dressing and was attached to a suction device with a canister which collected drainage from R37's stage 4 pressure ulcer. R37's skin was dark purple/ red in color with linen creases on her entire right side (from the shoulder to the bottom of her thigh.) The DON stated she felt R37's skin had creases imprinted from the linen, was damp from sweat and had blanchable redness on her right side shoulder, buttocks, hip and thigh. The DON confirmed R37 had a current stage 4 sacral pressure ulcer and indicated R37 was on a every hour side to side repositioning program. The DON and RN-B assisted R37 to her left side and positioned pillows covered in dry pillow cases. R37 had an alternating pressure mattress in place and had bilateral tan colored heel protectors on both heels.	2 900		

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2 900	Continued From page 16 On 2/8/16, at 6:36 p.m. the DON stated R37 required assistance for repositioning every hour side to side to prevent further skin breakdown. The DON confirmed R37 was at high risk for pressure ulcers. The DON stated R37 was not to lay on her back and was bedridden due to the stage 4 pressure ulcer on her sacrum. The DON stated she was unsure why R37 was not repositioned as ordered by the certified wound and ostomy nurse (CWON). The DON stated she expected staff to assist R37 to turn and reposition side to side every hour. The DON verified R37 had last been repositioned at 3:30 p.m. The DON verified R37 had remained on her right side for a total of 2 hours and 56 minutes. On 2/8/16, at 6:53 p.m. the assistant director of nursing (ADON) stated R37's wound was currently being routinely evaluated by a CWON. The ADON stated the a CWON had directed to reposition R37 side to side every hour to prevent further skin breakdown/pressure ulcers about a week ago when abrasions were noticed on R37's right side. ADON stated she was the person who was responsible for completion of the weekly wound assessments for R37. ADON stated R37 had been admitted with a stage 2 pressure ulcer on her sacrum and had been on a turn and repositioning program of every 2 hours. ADON stated R37's physician had evaluated R37's stage 2 pressure ulcer and identified R37 needed surgical debridement of the pressure ulcer. ADON stated R37 had a surgical debridement of the stage 2 pressure ulcer on 12/15 which had revealed R37 had a stage 4 pressure ulcer on her sacrum. ADON stated R37 required a diverting colostomy (a surgical procedure which diverts stool from the rectum to a opening in the abdomen which then empties stool into a bag,) so	2 900		

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2 900	Continued From page 17 a wound vac could be placed to R37's stage 4 sacral pressure ulcer. ADON indicated R37 had two pressure ulcer assessments in August and was unable to provide any further assessments in the electronic medical record (EMR) until December 2015. ADON confirmed there were no weekly wound assessments in R37's EMR from 8/16/15 to 12/15 for R37's pressure ulcer which worsened from a stage 2 pressure ulcer to a stage 4 pressure ulcer. On 2/8/16, at 7:10 p.m. nursing assistant (NA)-E stated she had last repositioned R37 around 3:30 p.m. NA-E stated she understood R37 was on a every 2 hour repositioning schedule and stated she was unaware R37 was supposed to be repositioned every hour. On 2/8/16, at 7:43 p.m. NA-A stated he had not assisted R37 to reposition since about 3:30 p.m. and stated R37 was supposed to be repositioned every 1-2 hours. NA-A stated staff were unable to assist R37 with repositioning because other residents had needed assistance. R37 had not been repositioned from 3:30 p.m. to 6:26 p.m. a total of 2 hours and 56 minutes. On 2/10/16, at 7:36 a.m. observations of R37's pressure ulcer care was conducted with CWON and ADON present in R37's room. A wound vac machine was observed attached by tubing to R37's stage 4 sacral pressure ulcer. The drainage collection cartridge of the wound vac contained reddish black drainage. ADON and CWON verified R37's drainage was reddish black and foul smelling. After the transparent dressing from R37's sacrum was removed, CWON stated R37 had a increased area of pressure on the left edge of the current pressure ulcer. CWON	2 900		

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2 900	Continued From page 18 identified R37 had necrotic tissue which extended 2 cm from the opening of the sacral ulcer and was present from a 9 o'clock position to the 11 o'clock position of the wound. CWON stated she felt R37 had been laying on one side too long and had caused pressure. CWON stated 0.5 cm x 1.0 cm of R37's sacral bone was visible at the 12-1 o'clock position. CWON stated R37's sacral wound had tunneling present from 9 o'clock to 3 o'clock. CWON stated R37's stage 4 sacral pressure ulcer measured 5.5 cm long x 6 cm wide and was 3.5 cm deep. CWON indicated R37 had superficial open areas from adhesive tape on her right buttocks and thigh both were 2 cm in diameter. She also stated she had re-educated staff after the transparent dressings used with the wound vac had been applied incorrectly and caused the new open areas on the buttocks. CWON stated R37 also had two 2 cm diameter blisters, one on each shoulder from shearing due to the lift sheet being kept under R37. The CWON stated R37's shearing areas were noted in early February and a different lift sheet had been ordered but had not arrived in facility at present. Review of R37's weekly wound assessments from 8/6/15, to 12/24/15, revealed the following: -On 8/6/15, identified R37 had been admitted to the facility with a stage 2 pressure ulcer on the buttocks. The assessment revealed R37's stage 2 pressure ulcer measured 2.1 cm x 2.2 cm x 0.1 cm and had 100% epithelial tissue present. The assessment identified current interventions of a pressure redistribution mattress and barrier cream to the ulcer every shift. -On 8/19/15, revealed R37's stage 2 pressure	2 900		

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2 900	Continued From page 19 ulcer measured 2.1 cm x 2.1 cm x 0.1 cm and had 100% epithelial (definition)tissue present. The assessment identified current interventions of a pressure redistribution mattress, barrier cream and a turn and repositioning program of every 2 hours. -On 12/24/15, identified R37 had a stage 4 sacral pressure ulcer. The assessment revealed R37's was admitted with a pressure ulcer which had become worse and required hospitalization for a surgical debridement of the sacral pressure ulcer. The assessment revealed R37's stage 4 pressure ulcer measured 8.2 cm x 8.6 cm x 5.1 cm, was red with 75% granulation (new vascular tissue in granular form on an ulcer or the healing surface of a wound) tissue, 25% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed,)tissue and had a moderate amount of serosanguineous (yellowish serum with small amounts of blood) drainage. The assessment revealed the skin surrounding R37's pressure ulcer was macerated/soft and the margins were undefined. The assessment further revealed no tunneling or odor were present. The assessment identified current interventions of a pressure redistribution mattress, turn and repositioning program of every 2 hours side to side, not to sit in a wheelchair and treatment of saline soaked kerlix (gauze packing) and cover with ABD (thick absorbent dressing,) and directed staff not to use tape on R37's skin at pressure ulcer site. The assessment revealed a wound vac was to be placed the following week following a diverting colostomy (diverts the bowel to an opening in the abdomen where a stoma is created.)	2 900		

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2 900	Continued From page 20 -On 1/7/16, revealed R37's stage 4 sacral pressure ulcer measured 9.2 cm x 10 cm x 5.2 cm, had undermining on the right side of the wound from 1 o'clock to 3 o'clock, had a moderate amount of serosanguineous drainage and no odor. The assessment revealed R37's pressure ulcer had 70% granulation and 30% slough tissue, surrounding skin was reddish and macerated. The assessment identified current interventions of wet to dry kerlix, cover with ABD and a plan to place a wound vac that week. -On 1/28/16, revealed R37's stage 4 sacral pressure ulcer measured 7 cm x 6 cm x 4.2 cm, had undermining on the top edges, had a moderate amount of serosanguineous drainage which had a strong odor. The assessment revealed R37's pressure ulcer had 50% granulation and 50% slough tissue, surrounding skin was macerated. The assessment identified current interventions of a wound vac changed on Monday, Wednesday, Friday, air mattress, side to side positioning and CWON or primary care provider (PCP) to monitor weekly. -On 2/1/16, revealed R37's stage 4 sacral pressure ulcer measured 6.3 cm x 7.1 cm x 3.6 cm, had a large amount of serosanguineous drainage which had a strong odor. The assessment revealed R37's pressure ulcer had 50% slough and 50% granulation tissue margins were maceration. The assessment identified current interventions of wound vac, pressure redistribution mattress, specific turn and reposition program and heel boots. The assessment lacked mention of R37's surrounding skin and whether undermining continued to be present.	2 900		

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2 900	Continued From page 21 -On 2/3/16, revealed R37's stage 4 sacral pressure ulcer measured 7 cm x 7 cm x 5 cm, had a moderate amount of serosanguineous drainage with no odor. The assessment revealed R37's pressure ulcer had 75% granulation tissue (did not identify the other 25% of tissue present,) had undefined, macerated margins and had maceration on the surrounding skin. The assessment revealed two areas of maceration from the transparent dressing adhesive pulling on R37's skin. The assessment identified current intervention of a wound vac, pressure redistribution mattress, wheel chair cushion, specific turn and repositioning program, positioning devices, heel boots. The assessment lacked the presence of undermining. R37's clinical record lacked documentation of wound assessments completed of R37's pressure ulcer from 8/19/15, to 12/24/15, a total of 4 months. Review of R37's clinical health status form dated 8/6/15, identified R37 had a 2 cm x 2.5 cm open area on the buttocks and an area of chaffed, denuded skin which measured 10 cm x 15 cm on the buttocks. The form identified R37's Braden scale (a scale used to predict risk for pressure sore development based on moisture, activity, mobility, nutrition, sensory, friction and shear,) score placed R37 at high risk for pressure ulcers. Review of R37's clinical health status form dated 12/24/15, identified R37 had a stage 4 sacral pressure ulcer and continued to be at high risk for developing pressure ulcers. Review of R37's tissue tolerance test (TTT, a test which measures tissue tolerance for sitting and lying) dated 8/10/15, revealed R37 had	2 900		

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2 900	Continued From page 22 normal skin over bony prominences after 2 hours of lying. The assessment revealed R37 was at high risk for developing pressure ulcers. Review of R37's TTT dated 12/28/15, identified R37 was able to tolerate 1.5 hours of lying without redness or signs of breakdown. The assessment revealed R37 had an order not to sit upright and was at severe risk for pressure ulcers. Review of R37's physician and CWON progress notes from 10/22/15, to 1/16, revealed the following; -On 10/22/15, CWON note identified R37 had three wounds which required assessment. The note identified R37 had wound on the buttocks related to shear/pressure, measured 6 cm x 9 cm x 0.1 cm and was pink with a 0.5 cm dark area in center. The note identified R37 had a wound on the lateral side of the right heel, pressure non-blanchable, measured 1 cm x 1 cm.. The note further identified R37 had a wound on the lateral left heel, pressure, non-blanchable, measured 1.5 cm x 1 cm. The note directed staff off load heels at all times, and to cleanse buttocks wound with normal saline and apply a large foam dressing windowed with transparent dressing and change every 3 days and as needed. The note directed to follow up with her as needed. -On 10/28/16, MD note identified R37 had a fairly large skin ulcer on the buttocks, decubitus ulcer. -On 12/01/15, MD note revealed R37's sacral wound was not assessed at the time of the visit. -On 12/15/15, MD note revealed R37's sacral ulcer was assessed and the wound was gaping	2 900		

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2 900	Continued From page 23 open and looked like a stage 4 ulcer. The note further revealed MD's plan was to have CWON assess R37's sacral ulcer the following day. -On 12/16/15, MD history and physical note revealed R37 had a sacral decubitus ulcer which had increased in size. The note revealed R37 had been seen at the facility on 12/15/15, the sacral ulcer had deteriorated and there was complete penetration of the skin and subcutaneous tissue in the ulcer. The note revealed there had been significant drainage and evidence of necrotic tissue. The note identified R37 had a stage 4 pressure ulcer with complete penetration of the subcutaneous tissue and a plan to have the ulcer surgically debrided that day. R37's record revealed R37 had been hospitalized from 12/30/15 to 1/6/16 for surgery for a diverting colostomy in order to place a would vac for treatment of the stage 4 pressure ulcer. -On 1/8/16, CWON note identified R37's sacral pressure ulcer measured 9 cm x 9 cm x 4 cm, had undermining at 11 o'clock of 3 cm. The note identified R37's pressure ulcer had 75% red wound base and some slough with a black area from 7-12 o'clock, moderate amount of serous drainage, no odor and had a 1 cm area of black of the wound edge at 11 o'clock. -On 1/14/16, CWON note identified R37's sacral pressure ulcer measured 8 cm x 7 cm x 5 cm with a 2 cm x 3 cm dry necrotic area of the wound edge at 4 o'clock. The note identified R37's pressure ulcer had 75% beefy red wound base with some adherent yellow slough. -On 2/3/16, CWON note identified R37 had 5 areas of concern. The note revealed R37's stage	2 900		

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2 900	Continued From page 24 4 sacral pressure ulcer measured 7 cm x 7 cm x 5 cm, had pink fascia (a thin sheath of fibrous tissue enclosing a muscle or other organ,) moderate serous drainage. The note identified R37 had an area in the right gluteal crease from shearing which measured 1.4 cm x 3 cm x 0.1 cm. The note revealed R37 had a sheared area on the left buttocks which measured 2.8 cm x 1 cm. The note revealed R37 had a pressure area on the left scapula which measured 4 cm x 10 cm and was described as a blanchable redness. The note further revealed R37 had a pressure area on the right scapula which measured 3 cm x 4 cm and was also described as a blanchable redness and had an intact blister 1 cm x 2 cm blister. The note identified R37 was to be assisted with repositioning every hour by staff and to observe for reddened areas and to obtain a turning sheet. On 2/9/16, at 2:28 p.m. during a phone interview the medical doctor (MD), he stated he felt R37's sacral pressure ulcer had likely always been a stage 4 ulcer as the edges of the wound had become suspicious. The MD stated he would expect facility staff to monitor R37's pressure ulcer weekly including measurements and tissue type. The MD also stated he would expect the facility staff to routinely reposition R37 from side to side. The MD also stated R37's pressure ulcer had started out as a small pressure ulcer, though wasn't straight forward with its appearance. The MD stated once the pressure ulcer was surgically debrided it was determined to be a stage 4. On 2/10/16, at 8:26 a.m. CWON verified R37 had a stage 4 pressure ulcer to her sacrum. CWON stated she felt R37's pressure ulcer had likely started out as an unstageable pressure ulcer and was able to be staged after the surgical debridement. CWON stated R37 should be	2 900		

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2 900	Continued From page 25 repositioned every 1 hour side to side. CWON stated she had recommended R37 be repositioned side to side hourly once R37 sides of her body had began to get red. CWON also stated R37 needed a different type of lift sheet due to the blisters and abrasions which had been ordered. On 2/10/16, at 9:01 a.m. during a follow up interview the DON stated they were unable to provide any comprehensive wound assessments for R37 from 8/19/15, to 12/24/15, and stated she were not sure what happened. The DON stated she expected R37's pressure ulcer to be assessed weekly and monitored daily. The DON stated she expected R37's care plan to be followed and recommendations from the CWON to be followed to aid in healing R37's pressure ulcer. On 2/10/16, at 3:13 p.m. the ADON provided hand written copies of documentation of wound monitoring for 16 dates between 9/7/15 and 12/21/5 which the ADON confirmed she had just recreated from random notes on her personal calendar and from post it notes which she had found in her office. The ADON stated the re-created assessments were not complete assessments, but she had written information on a wound evaluation flow sheet for the dates and measurements of the wound from the post notes and notes on her calendar. A facility policy for pressure ulcer prevention and treatment was requested and not provided. The facility provided a copy of the form CMS (centers for Medicare and Medicaid services) 2012 (7/20/15), titled Positioning Critical Element Pathway, which is a pathway for investigation of	2 900		

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2 900	Continued From page 26 positioning needs for residents in long term care facility. Review of the facility policy titled Pressure ulcers, nutritional services, reviewed 12/16/15, revealed the dietitian would be responsible for longing monitoring and documentation of resident status of nutritional needs with the presence of a pressure ulcer. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures for the appropriate care and services for pressure ulcers. The director of nursing or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure open food items in the kitchen's refrigerator and the resident's refrigerator located in the north dining room were sealed and dated when opened. This	21100	Corrected	3/21/16

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21100	Continued From page 27 had the potential to affect 23 of 24 residents who resided in the facility. Findings Include: On 2/7/16, at 9:08 a.m. the tour of the kitchen revealed the middle refrigerator had a package of cheddar cheese in it with masking tape loosely around the package opening (but not sealing the package), and the cheese was not dated when it was opened. Cook (C-A) verified the package of cheese was not sealed, and there was no open date on the package. C-A stated the cheese should be placed in a plastic container with a lid on it, and it should be dated. On 2/7/16, at 1:50 p.m. the refrigerator in the north dining room contained a pealed orange in a zip lock bag with one section of 2 slices that had a circular black spot in the center of it approximately 0.25 centimeters (cm) in size. In addition, in the same bag there was a 1/2 orange which had 3 dark circular areas on it; one area approximately 0.5 cm in size, one slightly smaller then 0.5 cm and the 3rd area was pinpoint in size. There was a resident's first name on the bag, but it was not dated. The refrigerator also contained a brown pie box with a resident's first name and last initial on it. The use date on the box was 12/28/15. The pie box contained 4 slices of pie. In addition, there was a quart of eggnog that had not been opened but had an expiration date of 1/6/16. At 2:10 p.m. registered nurse (RN-A) stated the refrigerator in the north dining room is used for the residents and their families. RN-A stated the oranges had mold on them and belonged to a resident that was no longer residing in the facility. RN-A verified the blueberry pie had a use by date of 12/28/15, and it should have been thrown away. RN-A stated the usual facility	21100		

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21100	Continued From page 28	21100		

practice was for housekeeping or maintenance to check the refrigerator daily and if the food is old or expired they would throw it away. RN-A stated if housekeeping or maintenance have concerns about the food or if they find outdated food in the refrigerator they would throw it away and would tell nursing. RN-A stated they should be checking the refrigerator daily and confirmed the food items were available for the residents in the north dining room and were outdated.

On 2/9/16, at 3:15 p.m. the dietitian (D)-D stated the expired blueberry pie, oranges with the dark spots and eggnog findings were not acceptable. D-D verified the food should have open dates on them and the moldy oranges discarded. D-D stated the dining department was to check daily for outdated food and open dates on food, and it had not been done daily. D-D stated they should be labeling and dating food items and checking that food is not spoiled or has not expired daily. D-D stated the cook should check for expiration dates, labels and open dates on the food package. The daily cleaning schedule indicated the a.m. and p.m. cook was to remove outdated food items.

Review of the facility January cleaning schedule from 1/4/16, to 1/31/16, identified the a.m. cook had not checked for outdated food items 16 out of 27 days and the p.m. cook had not checked for outdated food items 8 out of 27 days. Review of the February cleaning schedule from 2/1/16, to 2/9/16, identified the a.m. cook had not checked for outdated items 3 out of 9 days and the p.m. cook had not checked 1 out of 9 days.

The facility policy titled Storage of Refrigerated Foods reviewed 2/12/15, had indicated to monitor all items daily for expiration dates or use by dates

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21100	Continued From page 29 and discard all outdated items daily. SUGGESTED METHOD OF CORRECTION: The director of dietary services or designee could development and implement policies and procedures to ensure proper food storage. The director of dietary services or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21100		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use;	21390		3/21/16

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21390	Continued From page 30 H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi- use supply container was maintained in a sanitary manner. This had the potential to effect 2 of 2 residents (R11, R30) who currently utilized a shared container of items to monitor blood glucose. Findings include: On 2/07/16, at 12:03 p.m. registered nurse (RN)-B entered R11's room with a plastic container of glucometer supplies. The container had no cover and the sides of the container had the appearance of woven plastic strips with small open areas on all four sides. RN-B placed the container directly on to the top of R11's over-the-bed table. With gloved hands, RN-B removed an alcohol wipe, lancet and glucose strip from the container. Following the use of these items to check R11's blood glucose, RN-B carried the container to the bathroom with the same gloved hands, and placed the container on the top of the toilet tank. RN-B removed the soiled gloves, turned on the water faucet, and found no running water at this time. RN-B picked up the container of blood glucose supplies, carried it back to the medication cart and placed it directly on the top of the medication cart. RN-B disposed of the used lancet and blood glucose	21390	Corrected	

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21390	Continued From page 31 strip into a sharps container, and sanitized the glucometer with a germicidal bleach wipe. RN-A began to place the container into the top drawer of the medication cart with other resident medication items and was stopped by the surveyor. On 2/07/16, at 12:20 p.m. RN-B verified he/she had attempted to place the container into the top drawer of the medication cart without sanitizing the bottom of the container. RN-B identified it was not the usual facility practice to place multi-use containers onto unclean surfaces nor was it usual practice to return an item to the medication cart without sanitizing it. RN-B indicated the multi-use container should have been placed onto a paper towel on the over-the-bed table, and should not have been placed on top of the toilet tank. RN-B further indicated the bin should have been sanitized with a germicidal bleach wipe before placing it onto the top of the medication cart and returning it to the drawer. On 2/10/16, at 1:55 p.m. the director of nursing (DON) verified the container became contaminated when placed on top of the resident's over-the-bed table and the toilet tank, and agreed the multi-use container should have been sanitized before returning it to the medication cart. The DON identified the expectation that the container of supplies would remain in the medication cart. The DON stated "the supply basket should never leave the med [medication] cart." The facility policy titled Cleaning and Disinfection of Resident-Care Items and Equipment, reviewed 11/11/15, identified the resident care equipment would be cleaned and disinfected according to the CDC (Centers for Disease Control)	21390		

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21390	Continued From page 32 recommendations. The CDC web page Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008, identified "The ultimate goal of the Recommendations for Disinfection and Sterilization in Health-Care Facilities, 2008, is to reduce rates of health-care-associated infections through appropriate use of both disinfection and sterilization." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review the pertinent policies and procedures for ensuring infection control procedures were maintained with multi-use resident items. Education could be 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.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		3/21/16

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21426	Continued From page 33 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculin symptom screenings and two step skin test for tuberculosis (TB) were provided for 2 of 6 newly hired employees (E1) and the director of nursing (DON) in the sample. Findings include: E1 had a hire date of 1/5/16, no records of a TB symptom screen or skin tests were found. The DON had a hire date of 12/14/15, no symptom screen was found and the first skin test was administered on the survey entry date of 2/7/16, fifty five days after hire. On 2/9/16, at 3:00 p.m. the director of nursing (DON) verified a new form for TB had been implemented and no symptom screen had been completed for her upon hire, and the first skin test was recently administered. The DON verified no documentation of symptom screen or skin tests could be found for E-1. The DON agreed a symptom screen should have been completed along with a two step skin test upon hire and the	21426	Corrected	

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21426	Continued From page 34 records should have been maintained. The facility policy titled Tuberculosis, Screening Employees and New Hires reviewed 8/14/15, Identified Policy Statement : All employees shall be screen [sik] for tuberculosis (TB) infection and disease, using a two-step tuberculin skin test (TST) or blood assay for Mycobacterium tuberculosis (BAMT) and symptom screening, prior to beginning employment. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could review and update procedures and educate staff to ensure that current CDC recommendations for Tuberculosis are practiced. TIME PERIOD FOR CORRECTION: Seven (7) days.	21426		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for	21535		3/21/16

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21535	Continued From page 35 Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed monitor the ongoing effectiveness of an antidepressant (Celexa) medication for 1 of 5 residents (R30) utilized for obsessive compulsive disorder. Findings include: R30's quarterly Minimum Data Set (MDS) dated 1/18/16, identified R30 was cognitively intact and had no behaviors, hallucinations or delusions during the assessment period. R30's current care plan revised 5/16, directed care which included: diabetes, activities, oral care, and physical functioning, however, did not address the use of Celexa related to obsessive compulisive disorder and monitoring of those beahviors. R30's current medication orders signed by the physician 1/14/16, identified R30 received Celexa 20 milligrams (mg) daily for the diagnoses of OCD (obsessive compulsive disorder)/anxiety with start date of 11/18/15. Review of R30's physican note dated 11/3/15, revealed R30 had been started on Celexa 10mg daily for OCD/anxiety for delusions of greens	21535	Corrected	

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21535	Continued From page 36 worms and obsessive thoughts of cleaning her jewelry which seemed to occupy her thoughts and time. Review of R30 phsycian note dated 11/17/15, revealed R30's dose of Celexa had been increased to 20 mg daily for continued delusions and hallucinations. Review of R30's clinical record, 11/19/15 through 2/2/16 and review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) January and February, lacked documentation of monitoring of the effect of Celexa related to behaviors for the diagnosis of OCD. On 2/10/16, at 11:08 a.m. the assistant director of nursing (ADON) verified R30 currently received Celexa 20 mg daily for the diagnosis of OCD behaviors with a start date of 11/18/15. The ADON verified the current care plan did not address R30's use of Celexa for OCD behaviors. The ADON indicated with orders of Celexa for OCD staff had been expected to enter specific target behaviors and side effects of the medications into the MAR and the TAR. The ADON identified the nurses would then review and document every shift if the behaviors or side effects were present and if so, would write a progress note explaining the specifics of the behavior and/or side effects. On 2/10/16, at 1:55 p.m. the director of nursing (DON) indicated R30's care plan should have included the use of Celexa, with target behaviors and interventions. The DON verified documentation should have been completed for monitoring of side effects.	21535		

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21535	Continued From page 37 The requested facility policy was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring medication regimen review. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure residents are not receiving unnecessary medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter	21540		3/21/16

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21540	Continued From page 38 directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility consulting pharmacist failed to identify the irregularity for 1 of 1 residents (R30) who lacked ongoing monitoring of the effectiveness of an antidepressant (Celexa) medication ordered to treat obsessive compulsive disorder. Findings include: R30's quarterly Minimum Data Set (MDS) dated 1/18/16, identified R30 was cognitively intact and had no behaviors, hallucinations or delusions during the assessment period. R30's current care plan revised 5/16, directed care which included: diabetes, activities, oral care, and physical functioning, however, did not address the use of Celexa related to obsessive compulsive disorder and monitoring of those behaviors. R30's current medication orders signed by the physician 1/14/16, identified R30 received Celexa 20 milligrams (mg) daily for the diagnoses of OCD (obsessive compulsive disorder)/anxiety with start date of 11/18/15. Review of R30's physician note dated 11/3/15, revealed R30 had been started on Celexa 10mg daily for OCD/anxiety for delusions of greens worms and obsessive thoughts of cleaning her jewelry which seemed to occupy her thoughts and time. Review of R30 physician note dated 11/17/15,	21540	Corrected	

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21540	Continued From page 39 revealed R30's dose of Celexa had been increased to 20 mg daily for continued delusions and hallucinations. Review of R30's clinical record, 11/19/15 through 2/2/16 and review of the Treatment Administration Record (TAR) and Medication Administration Record (MAR) January and February, lacked documentation of monitoring of the effect of Celexa related to behaviors for the diagnosis of OCD. Review of R30's progress notes from 11/16/15 to 2/10/16 revealed the following pharmacy notes: -12/8/15, resident placed on citalopram (Celexa), dose increased to 20 mg 11/15 to help manage anxiety, appears to tolerate. Will continue to monitor. -1/15/16, no recommendations On 2/10/16, at 11:08 a.m. the assistant director of nursing (ADON) verified R30 currently received Celexa 20 mg daily for the diagnosis of OCD behaviors with a start date of 11/18/15. The ADON verified the current care plan did not address R30's use of Celexa for OCD behaviors. The ADON indicated with orders of Celexa for OCD staff had been expected to enter specific target behaviors and side effects of the medications into the MAR and the TAR. The ADON identified the nurses would then review and document every shift if the behaviors or side effects were present and if so, would write a progress note explaining the specifics of the behavior and/or side effects. On 2/10/16, at 1:55 p.m. the director of nursing (DON) indicated R30's care plan should have	21540		

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21540	Continued From page 40 included the use of Celexa, with target behaviors and interventions. The DON verified documentation should have been completed for monitoring of side effects. On 2/10/16 at 2:55 p.m. a call was placed to the consulting pharmacist for interview and message was left. No return call was received during or immediately after survey. The requested facility policy was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review the pertinent policies and procedures for medication monitoring. Education could be 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.	21540		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21805	Corrected	3/21/16

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21805	Continued From page 41 review, the facility failed to ensure personal dignity during leisure activities and meal service for 1 of 3 residents (R24) observed to utilize a gait belt for ambulation. Findings include: R24's quarterly Minimum Data Set (MDS) dated 11/18/15, identified R24 had moderate cognitive impairment, required extensive assistance from staff for personal hygiene, dressing, toileting and transferring. R24's Care Area Assessment (CAA) dated 8/28/15, identified diagnoses which included cerebral vascular accident, blindness, depression, and hard of hearing. R24's current care plan revised 1/28/16, identified R24 had visual deficit due to blindness, hearing deficit and had physical impairments. R24's care plan listed various interventions which included staff assistance with ambulation with a gait belt and walker related to blindness, explain cares, encourage choices with cares, offer verbal cues and guidance. Observations on 2/8/16, identified the following: - At 3:55 p.m. R24 was assisted to walk by nursing assistant (NA)-E. R24 walked with a wheeled walker and wore a dark blue gait belt around his/her waist. -At 5:25 p.m. R24 was observed seated in a stationary chair, at a table in the dining room. The blue gait belt remained fastened around his/her waist. R24 had a brown cloth napkin/clothing protector on his/her chest, and cups of fluids with handles and straws were on	21805		

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21805	Continued From page 42 the table in front of R24. -At 5:27 p.m. NA-E sat at the table to the right side of R24. NA-E offered R24 a drink and then explained coffee, chocolate milk and orange juice were available on the table in front of R24. -At 5:29 p.m. NA-E stood from the table and assisted other residents in the dining room with clothing protectors, drinks and meals. R24 remained seated at the table with the dark blue gait belt fastened around his/her waist. - At 5:46 p.m. the facility Dietitian delivered R24's evening meal. -At 5:46 p.m. NA-A sat to the right side of R24 at the dining table. NA-A assisted R24 with eating, explaining where items were, handing utensils and bowls of foods to R24 and spooning foods directly into R24's mouth. The dark blue gait belt remained fastened around R24's waist throughout the evening meal service. -At 6:12 p.m. NA-A turned R24's stationary chair away from the table, placed the wheeled walker in front of R25 and assisted him/her to stand. NA-A guided R24 to walk through the dining room. NA-A did not grasp the gait belt to assist R24 to walk. NA-A instead held on to the front right side of R24's wheeled walker, and then the left front side of the walker until R24 had reached his/her room. -At 6:15 p.m. NA-A grasped the gait belt and assisted R24 into the bathroom without the use of the wheeled walker. -At 6:25 p.m. R24 was laying on his/her back in bed on top of the covers with three small blankets	21805		

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21805	Continued From page 43	21805		

draped over R24's legs. R24 had head phones on listening to the television. The dark blue gait belt remained fastened around R24's waist.

-At 7:07 p.m. the director of nursing (DON) assisted R24 to donn slippers, rise from the bed and walk down the hall towards the dining room for bingo. The DON walked R24 from his/her room down the hall with the gait belt which had remained fastened around R24's waist throughout the evening.

-At 7:15 p.m. R24 was seated at a table in the dining room between the bingo caller and a resident who was identified by R24 as a personal friend. The dark blue gait belt remained fastened around R24's waist throughout the observation of the bingo game which was completed at 7:51 p.m.

On 2/08/16, at 6:28 p.m. NA-A verified R24 had the gait belt on throughout the evening meal, and R24 currently continued to have the gait belt on while laying in bed. When questioned about the gait belt remaining fastened around R24's waist NA-A stated "[R24] will go down to bingo in a half hour." NA-A indicated that R24 did not always have the gait belt fastened around his/her waist. NA-A indicated at times R24 had been seated in the front lobby with a female resident and at that time the gait belt was loosened. NA-A stated "[R24] has never complained" about wearing the gait belt for extended periods of time.

Observations on 2/9/16, identified the following:

-At 2:54 p.m. NA-F assisted R24 to walk down the hall from his/her room to the dining room for cookies and coffee. NA-F seated R24 in a stationary chair and left the room. The dark blue

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21805	Continued From page 44 gait belt remained fastened around R24's waist through the snack and visiting time. -At 3:46 p.m. R24 was seated in the lobby in a stationary chair by the wall with a female resident. The dark blue gait belt remained around R24's waist. On 2/09/16, at 10:45 a.m. NA-B identified R24 utilized a gait belt to assist with walking and to provide safety. NA-B indicated R24 had not fallen while at the facility; however, had a knee that possibly may go out and R24 saw only shadows. NA-B identified it was not the usual facility practice to leave a gait belt fastened around a resident's waist when not walking with the resident. NA-B verified the gait belt should have been removed when R24 was seated in the dining room. On 2/09/16, at 12:50 p.m. the DON verified gait belts should be removed from around a resident's waist anytime when not walking. On 2/09/16, at 3:48 p.m. NA-G verified R24 had a gait belt on at this time while seated in the lobby visiting with a female resident. NA-G identified R24 utilized a gait belt for all transfers and walking. NA-G indicated gait belts were only fastened around R24's waist when being used and stated "I take it off when [R24] sits down, or is at the table." On 2/10/16, at 7:12 a.m. during interview, R24 indicated staff often applied the gait belt around R24's waist and it would remain in place all day. R24 stated staff had not asked if leaving the gait belt around R24's waist bothered [R24]." R24 stated "I probably look like hell, I can't see to take care of myself."	21805		

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21805	Continued From page 45 The facility policy titled Transfer Activities, reviewed 1/26/15, directed staff with use of a gait belt; however, the policy did not address when the gait belt was to be removed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures to ensure all residents are treated with dignity. The director of nursing or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in	21830		3/21/16

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21830	Continued From page 46 writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.	21830		

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21830	Continued From page 47 (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to accommodate resident preferences for bathing for 2 of 2 residents (R30, R11) reviewed for bathing preferences. Findings include: R30 indicated on 2/07/16, at 4:29 p.m. he/she received a bath two times a week and stated "I really should have a bath every day" because of	21830	Corrected	

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21830	Continued From page 48 incontinence of loose stools. R30's quarterly Minimum Data Set (MDS) dated 1/18/16, identified R30 had intact cognition, required extensive assistance with transfers, mobility, toilet use, hygiene and dressing, and was frequently incontinent of bowel and bladder. The physician progress note dated 11/3/15, identified diagnoses which included incontinence, diarrhea, and colon cancer. Review of the facility bath schedule February 1 through February 9, noted R30 had received two baths a week, Thursday and Sunday. On 2/10/16, at 8:47 a.m. NA-D indicated R30 had intact memory, received a bath two times a week on Sundays and Thursdays. NA-D identified if residents asked for additional baths staff tried to fulfill the request or would pass it on to the next shift. NA-D stated "[R30] tells me [he/she] wished [he/she] could have a bath every day,we try but most times can't." NA-D identified since the beginning of November staffing had been cut; however, R30 was not given more baths prior to having less staff scheduled. NA-D stated "We don't have time." R11 on 2/07/16, at 12:00 p.m. identified he/she received a bath once a week. R11 stated "I have told them I would like more and they said they have too many people." R11 indicated he/she had talked to a nurse and the bath aide to request more than one bath per week. R11's physician's progress note dated 11/24/15, identified diagnoses which included super-morbid obesity, limited mobility, peripheral neuropathy, chronic kidney disease and diabetes.	21830		

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21830	Continued From page 49 R11's admission MDS assessment dated 11/27/15, identified R11 had intact cognition, and required extensive assistance with transfers, mobility, toilet use, hygiene and dressing, was frequently incontinent of bowel and bladder, and required total assistance with bathing. The nursing assistant care sheets identified R11 was frequently incontinent of bowel and bladder and received a bath on Wednesdays. Review of the bath schedule February 1 through February 9, noted R11 had received one bath a week, on Wednesday. On 2/09/16, at 10:55 a.m. NA-B identified R11 was unable to go into the bathroom to wash. NA-B indicated R11 was given a wash cloth and a towel to wash daily and received a tub bath one time a week. On 2/10/16, at 8:31 a.m. The licensed social worker (LSW)-F identified she did not coordinate resident bathing schedules. LSW-F indicated the nurses scheduled bathing and reviewed preferences. LSW-F identified her involvement with bathing was to inquire resident preferences of tub baths versus showers and how important the choice is to the resident, for documentation on the MDS. On 2/10/16, at 11:33 a.m. the assistant director of nursing (ADON) identified a bathing schedule was initiated upon admission to the facility; however, if a resident voiced a request for more baths staff would try to accommodate the request. The ADON indicated being unaware R30 or R11 had made requests for more baths. On 2/10/16, at 1:55 p.m. the director of nursing (DON) identified each resident received one bath	21830		

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21830	Continued From page 50 or shower per week unless they had incontinence issues or a request for more baths or showers. The DON stated "If a resident requests more, we make every effort to accommodate them." The Don verified the usual facility practice was to honor resident requests. The requested facility policy was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures to ensure all residents are offered choices in their daily preferences. The director of nursing or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21830		