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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5UEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245509**
2.STATE VENDOR OR MEDICAID NO.
(L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/20/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Josephine Hassinger, HFE NE II 10/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/07/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245509

October 16, 2014

Ms. Georgette Hinkle, Administrator
Adams Health Care Center
810 West Main Street
Adams, Minnesota 55909

Dear Ms. Hinkle:

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 September 17, 2014 the above facility is certified for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds located in rooms .

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 16, 2014

Ms. Georgette Hinkle, Administrator
Adams Health Care Center
810 West Main Street
Adams, Minnesota 55909

RE: Project Number S5509023

Dear Ms. Hinkle:

On September 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 20, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 29, 2014 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 August 20, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 17, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 20, 2014, effective September 17, 2014 and therefore remedies outlined in our letter to you dated September 9, 2014, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245509	A. Building B. Wing **01 - MAIN BUILDING 01**	9/29/2014

Name of Facility	Street Address, City, State, Zip Code
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **09/10/2014**	ID Prefix	Correction Completed **09/17/2014**	ID Prefix	Correction Completed **09/11/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0038		LSC K0046	
ID Prefix	Correction Completed **08/19/2014**	ID Prefix	Correction Completed **08/15/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0062		LSC K0147		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KFD	10/16/2014	25822	09/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/13/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245509	A. Building B. Wing	10/14/2014

Name of Facility	Street Address, City, State, Zip Code
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **08/22/2014**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **09/17/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/17/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/17/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/17/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **09/17/2014**
ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **09/17/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/17/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/17/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/17/2014**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **09/17/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/17/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/17/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/KFD	10/16/2014	33559	10/14/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/20/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5UEX

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00754

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245509**

2.STATE VENDOR OR MEDICAID NO.
(L2) **015540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ADAMS HEALTH CARE CENTER**
(L4) **810 WEST MAIN STREET**
(L5) **ADAMS, MN** (L6) **55909**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/20/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 09/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/02/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5509

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction

In addition, at the time of the August 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5509020 that was found to be unsubstantiated.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 9, 2014

Ms. Georgette Hinkle, Administrator
Adams Health Care Center
810 West Main Street
Adams, Minnesota 55909

RE: Project Number S5509023 and Complaint Number H5509020

Dear Ms. Hinkle:

On August 20, 2014, 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. In addition, at the time of the August 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5509020.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 20, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5509020 that was found to be unsubstantiated.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 September 29, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 29, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 20, 2014 (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 February 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245509	A. BUILDING _____ B. WING _____	08/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation (H5509020) were also completed at the time of the standard survey. Complaint H5509020 was was not substantiated during this survey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time	F 156		8/22/14

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

Electronically Signed | 09/18/2014

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

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of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy

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F 156	Continued From page 2 groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 4 residents (R16) reviewed for Medicare denial letters had identified whether or not to submit the bill to Medicare for review. Findings include: R16 was discharged from Medicare on 2/7/14, due to achieved maximum potential in skilled therapy, according to Skilled Nursing Facility Determination form on Continued Stay, issue	F 156	Please note that our signature and with either the response does not mean that we agree with either the tagged deficiency or the evidence presented to support any determination of non-compliance. We respond and provide a written plan of correction because the law requires it. Per the Adams Health Care Center's policy, Medicare denial letters will be mailed at least 2 days prior to the non-coverage effective date in the event	

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F 156	Continued From page 3 dated of 2/4/14. Document review of the facility cover letter, dated 2/4/14, which was sent to the family along with the two denial letters, said, Enclosed you will find a Medicare A Denial letter for R16. R16 has achieved maximum potential in skill therapy and R16's last day will be Thursday, February 6, 2014. Please read the front and back of the enclosed Medicare denial letter and make your selection on the back. Sign and date the colored copies where indicated on the forms and return them to Adams Health Care Center in the envelope provided. Keep the white copy for your records. If you have any questions please give me a call at the number listed above. The letter was signed by health unit coordinator. Document review of facility Skilled Nursing Facility Determination on Continued Stay, issue dated of 2/4/14, revealed a family member was notified of Medicare non coverage by telephone on 2/4/14. The Medicare denial letter lacked any representative signature and lacked decision to submit or not submit bill to Medicare for review. During interview on 8/13/14, at 11:45 a.m., financial director verified R16 was discharged from Medicare Part A services and still resided in the facility. Financial director verified R16's, Skilled Nursing Facility Determination on Continued Stay lacked decision to submit or not submit the bill to Medicare for review. Financial director stated she did not follow-up with denial letters. Document review of facility Medicare Denial Procedure policy undated directed staff: "6. In the event the appropriate party is	F 156	that the appropriate party is unavailable and a notation of attempts of all notification will be documented. Policy reviewed by Finance Director, DON, Administrator and HUC on 08/21/2014. Random audits will be conducted on a regularly basis by DON and/or her designee. Results will be reviewed by QA/QI for further recommendation.	

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F 156	Continued From page 4 unavailable the letter of denial will be mailed at least two days prior to the non-coverage effective date. A notation of attempts of notification will be documented."	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R5) was assessed to be safe to self-administer a nebulizer treatment. Findings include: On 8/14/14 at 7:09 a.m., R5 was observed in her room sitting in her wheelchair, sleeping and no staff were present. R5 had a nebulizer mask on, the machine was running, and there was no medication left in the cup. According to the physician progress note dated 7/2/14, R5 had a Brief Interview for Mental Status (BIMS) of 5 on 5/25/14, indicating severe cognitive impairment. It also indicated that R5 had a diagnosis of chronic obstructive pulmonary disease, oxygen dependent, and pneumonia. The physician's orders dated 7/214 indicated that R5 was to receive DuoNeb (ipratropium-albuterol) solution for inhalation therapy once a day.	F 176	R5 nebulizer treatment is administered by licensed staff and R5 is monitored by staff during treatment administration as of 08/21/2014. All residents having the potential to be affected by this deficient practice will be assessed for safety of self-administration of medication. Licensed staff educated on 09/17/2014 on self-administration of medication and on administration of nebulizer treatment. Audits will be conducted once per week for a month and once per month for 3 months. DON and/or her designee is responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and for further recommendation.	9/17/14

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F 176	Continued From page 5 An assessment dated 2/18/14 titled Self Administration of Drugs, documents that R5 had been informed of her right to self-administer drugs and she chose to defer the responsibility to the facility. During an interview on 8/14/14 licensed practical nurse (LPN)-C as she checked on R5. LPN-C stated that R5 was done with the nebulizer and removed it from C5 ' s face. LPN-C stated that the resident had just started the nebulizer. R5 woke and stated, " I think you [reference to LPN-C] forgot about me." LPN-C confirmed that there was no order for R5 to self-administer the nebulizer. LPN-C stated she had to go do something else and didn't get back to R5 right away. During an interview on 8/14/14 at 12:30 p.m., the director of nursing (DON) confirmed that R5 had no assessment to self-administer the nebulizer, that she had spoken to LPN-C and that LPN-C had told her that she had left the resident alone to work with another resident real quick and come back. The policy titled Self Administration of Medication, dated 3/28/13 reads: On admission, the admissions person asks the resident whether he/she wishes to self-administer drugs. The resident has the right to defer the responsibility to the facility. If the resident expresses the desire to self-administer their medication, an assessment will be completed by a registered nurse to determine their capability. A physician's order will be obtained and recorded in the chart.	F 176		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		9/17/14

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F 225 SS=E	Continued From page 6 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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F 225	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report an allegation of abuse to the designated state agency for 1 of 9 residents (R18) reviewed for abuse and neglect; failed to immediately report an allegation of neglect to the designated state agency for 1 of 9 residents (R68) reviewed for abuse and neglect; and failed to ensure 7 of 9 residents (R18, R68, R1, R6, R12, R20, R25) reviewed for allegations or actual abuse and neglect incidents were comprehensively investigated and immediate measures put into place to provide protection to the residents involved or potentially at risk due to lack of monitoring staff who committed the abuse. This had the potential to affect all 45 residents in the facility as they are all vulnerable adults. Findings include: ABUSE PROHIBITION PROTOCOL: Document review of facility Abuse Prohibition Protocol, updated 7/8/14 read, "...Adams Health Care Center's mission is to provide services in a safe and secure living environment, and to maintain the dignity and rights of all persons charged to our care ... Initial reports must be made immediately. Incident reports must be made to the CEP [common entry point] and OHFC [office of heath facility complaints immediately ... Investigation: All reports of alleged abuse, neglect, maltreatment, injuries of unknown source, and/or misappropriation of property shall be promptly and thoroughly investigated by facility management ... (F): in addition the Social Worker will review the	F 225	Per Adams Health Care Center Policy all allegations of abuse and neglect will be reported immediately to the designated state agency. A comprehensive investigation will be conducted and the staff involved will be monitored for compliance to prevent reoccurrence. All staff reeducated on 09/17/2014 regarding Abuse Protection Protocol, resident allegation of abuse, investigation and protection and reporting. Audits will be conducted once per week for a month and once per month for 3 months. Social Services Director, DON, Administrator and/or their designee will be responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and for further recommendation.	

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resident(s) medical chart, care plan and interview roommates, family members, and visitors who may service as witnesses to the incident, or give information leading up to the incident. Protection: The facility will protect residents from harm during the investigative process. All attempts will be made to maintain the resident's safety, dignity, rights, liberties and sense of well-being during and after the investigation of the incident ... The resident will be free from possible retaliation by the suspected staff members by means of rescheduling or relocating the suspected staff member, and by monitoring the suspected staff member during his/her presence in the facility ... Definitions Related To The Abuse Protocol ... Abuse- Is conduct (not accidental or therapeutic) that procedures or could produce intentional pain or emotional distress for the VA [vulnerable adult]. This includes; willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, metal anguish or deprivation."

AUDITS OF STAFF TREATMENT OF RESIDENTS:

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A stated audits of staff treatment of residents were included in care conference notes and in resident council minutes, if there were any concerns. LSW-A stated the audit was to ask a "general question- are there any concerns with staff or cares?" LSW-A verified there was no other documentation of audits for staff treatment of residents. LSW-A stated staff were educated on resident rights January 2014. If they did not attend, then had to make up the in-service. LSW-A stated she expected staff to speak

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F 225	Continued From page 9 respectfully to residents. Document review of resident council notes from 1/2014 to 8/2014, revealed no questions regarding staff treatment or cares. Document review of care conference notes 1/1/14 to 8/20/14, revealed no questions or notes regarding staff treatments or cares. The facility lacked documented evidence of audits of staff care and treatment. STAFF VULNERABLE ADULT TRAINING: Document review of staff training on resident rights and vulnerable adult training conducted on 1-8-14, revealed all staff identified in incident reports received training with the exception of one staff hired 3/14/14, who received the training on 3/14/14. ADMINISTRATOR EXPECTATIONS for a COMPREHENSIVE INVESTIGATION OF AN ALLEGED ABUSE OR NEGLECT INCIDENT: During an interview on 8/20/14 at 2:33 p.m., the administrator stated she expected interviews to be completed with other residents and staff as part of vulnerable adult investigation. The administrator stated she expected staff and resident interviews to documented and kept as part of the investigation and filed in the social service office. The administrator stated the director of nursing, licensed social worker, and administrator completed audits to monitor resident cares and interactions when there was a concern identified with a specific staff member.	F 225		

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F 225	Continued From page 10 The administrator verified there was no documentation to show the monitoring or audits had been completed. RESIDENT ALLEGATION OF ABUSE, INVESTIGATION, and PROTECTION: R18's quarterly Minimum Data Set (MDS) dated 7/10/14 revealed R18 had diagnoses of Dementia and Depression. R18 had severe cognitive impairment with clear speech. R32 required extensive assistance with one staff with dressing, limited assist of one staff for bed mobility, and supervision with one staff for transfers and locomotion. The care plan dated 7/23/14 indicated R18 was, " alert and orientated to person and place ... has some confusion with time and dates. Is able to communicate needs. Is able to make simple decisions independently. " During an interview on 8/12/14, at 11:03 a.m. family (F)-B member stated she was at the facility sometime in July 2014 when R18 voiced a concern to her regarding the remote control for the television not working. FM-B stated she left the facility went home and got new batteries, returned to the facility, placed new batteries in the remote and the remote still did not work. FM-B stated she went to look at the controls and there was a piece of black Velcro tape over the volume control. FM-B stated she alerted staff to this concern and removed the tape from the television. FM-B stated the concerns related to the television and staff approach with R18 were discussed at the care conference held in July of this year. FM-B stated facility staff apologized and stated the incident with R43 ' s television should not have happened. FM-B also stated at care	F 225		

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conference when concerns with staff approach was discussed, stated was told by the facility some of their staff have an approach that is " rough around the edges " and he may perceive this as staff not wanting to help him. Stated she was told the facility was working on staff approach on how to speak to residents.

The care conference progress noted dated 7/25/14 progress note read, " ...Family then asked about the incident regarding a Velcro adhesive being placed on the volume receptor on Resident's TV. [F-B] came to visit resident one afternoon and asked why his TV volume was so low. Resident reported that the remote didn't' work, so [F-B] left to go get batteries from home. [F-B] returned and placed them in the remote and states it still did not work. [F-B] then went up to the TV to find a volume control button, at which time [F-B] found the Velcro. [F-B] states [F-B] was caught off guard by this and took the Velcro to a nurse. Social Services informed the [F-B] that this incident had already been brought to the attention of the Administrator, DON, and Social Services and the staff responsible for doing this had been talked to. The [F-B] then stated, " Well I know there are problems with getting [R43] to keep his volume down. I was frustrated when I found it because I had spent so much time trying to fix the remote. ' Social Services assured the [F-B] that this kind of behavior from staff is not allowed and it is considered resident manipulation. Assured [F-B] that this is being monitored so it does not happen again ... "

During an interview on 8/20/14 at 9:40 a.m., the LSW-A verified placing Velcro black tape over the volume control of R43's television would be considered a punishment that resulted in

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deprivation in R43's ability to use the television in R43's room and would be considered maltreatment/abuse.

LSW-A verified a vulnerable adult report was not made to the designated state agency and stated a report should have been completed. When asked what measures were put into place to provide protection to R43 and other residents in the facility, LSW-A stated the facility was monitoring the staff (nursing assistant [NA]-V) identified in the incident. When asked how the facility was monitoring NA-V on the night shift, the LSW-A verified monitoring of NA-V was not being done. LSW-A verified she did not interview other staff members in regard to this incident as a part of the investigation process either. LSW-A also verified there was no documentation of the interviews she completed with residents in the facility neither as a part of the investigation or of the audits completed of the television to ensure Velcro taped had not been placed back over the volume control of R43's television nor if it had occurred to another resident in the facility.

During an interview on 8/20/14 at 2:33 p.m., the administrator stated she thought a vulnerable adult report had been completed for this incident and stated, "Yes, the placing Velcro black tape over the volume control of [R43's] television would be considered a punishment that resulted in deprivation in R43's ability to use the television in R43's room and would be considered maltreatment/abuse. " The administrator stated a vulnerable adult report should have been made and verified the facility did not follow their facility abuse prohibition protocol which included the need to report alleged abuse in this case to the designated state agency.

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F 225	Continued From page 13 During an interview on 8/20/14 at 2:33 p.m., the administrator stated she expected comprehensive interviews to be completed with other residents and staff as a part of a vulnerable adult investigation. The administrator stated she expected the staff and resident interviews to be documented and kept as a part of the investigation and filed in the social service office. The administrator stated the director of nursing (DON), LSW-A and the administrator completed ongoing audits to monitor resident cares and interactions when there was a concern identified with a specific staff member. The administrator verified there was no documentation to show the monitoring or audits had been completed. ALLEGATION OF NEGLECT, INVESTIGATION and PROTECTION OF RESIDENTS: R68 had diagnosis that included cerebrovascular accident and aphasia according to document review of the admission Minimum Data Set (MDS) an assessment dated 7/2/14. Document review of the same MDS identified R68 required extensive assist of one to two staff for activities of daily living, extensive assist of two staff for transfers and toileting, had short and long term memory problem and moderately impaired decision making. Document review of the facility resident care plan dated 7/15/14, directed R68 had impaired mobility related to cerebrovascular accident, generalized weakness, required physical assistance with transfers and ambulation, unsteady gait and balance. The care plan directed physical assist of one staff for transfers and had history of self-	F 225		

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F 225	Continued From page 14 transfers. Document review of facility investigation report submitted to the designated state agency (Office of Health Facility Complaints) dated 7/10/14, identified the following: Date of incident was 7/9/14. Maltreatment identified was neglect. R68 required assist of one staff for activities of daily living and transfers, although R68 had history of transferring self. Maintenance staff found R68 on the floor, reported to licensed wing nurse who responded " I don ' t have time for that. " Maintenance felt the remark was rude and felt the nurse neglected to respond immediately. LSW-A was notified of the 7/9/14 incident by the director of nursing on 7/10/14. LSW-A interviewed maintenance staff, nurse involved, and one nursing assistant. Review of a hand written note on the OHFC report fax sheet revealed director of nursing was notified on 7/9/14 by maintenance staff and was notified by wing nurse at 8:30 a.m., and " Did not see any discrepancy, because nurse states she was in the room at 8:05 to help resident." Review of director of nursing interview hand written note dated 7/10/14, at 11:45 a.m., revealed the director of nursing received a telephone message about the fall at 10:00 a.m. Director of nursing stated the message was at 8:15 a.m. and stated, " I did not report this to Social Services because there was no discrepancy. The fall occurred at 8:05 am [a.m.] & the nurse had reported it to me by 8:15." Although maintenance staff indicated the fall incident for R68 was witnessed by the oxygen delivery person, there was no documented evidence that the oxygen delivery person was interviewed regarding the incident.	F 225		

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Document review of facility Resident Incident/Fall Report dated 7/9/14, revealed fall occurred on 7/9/14 at 8:05 a.m., when janitor reported man on the floor. R68 was unable to speak and no medical treatment needed.

Document review of facility care conference note dated 7/15/14, identified R68 and family discussed therapy, plans to return home, stated pleased with care resident received. There were no questions or comments on staff treatment of resident.

Although the incident occurred on 7/9/14, at 8:05 a.m., the facility did not immediately report the incident of suspected neglect to the designated state agency until 7/10/14, at 11:35 a.m.

During telephone interview on 8/20/14, at 9:40 a.m., LSW-A stated she was notified of the incident on 7/10/14. LSW-A stated she expected the nurse to respond immediately. LSW-A stated she interviewed the nurse (licensed nurse [LN-A]) and maintenance staff involved. She stated LN-A reported that she had to lock up medications and then responded to R68 on the floor. LSW-A verified no other staff or residents were interviewed. LSW-A verified the 7/9/14 incident of potential neglect was not immediately reported to the facility or to the designated state agency.

During interview on 8/20/14, at 3:03 p.m., the administrator stated she was not aware of the incident of potential neglect until the following day.

The facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person,

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and the facility lacked evidence of monitoring LN-A for compliance and to prevent reoccurrence of an incident like the one with R68. Also there was no documentation provided in regards to the protection of R68 during the investigation of the allegation of neglect.

R1 had diagnosis that included heart failure and dementia according to document review of R1's admission Minimum Data Set (MDS), an assessment dated 7/24/14. Document review of the same MDS identified R1 had severe cognitive impairment and required the assistance of one staff for activities of daily living which included toileting and transfers.

Document review of facility resident care plan dated 8/11/14, directed staff R1 had impaired mobility related to generalized weakness, and needed physical assistance of one for bed mobility, transfers, ambulation, and wheelchair locomotion.

Document review of facility investigation report submitted to the Office of Health Facility Complaints dated 7/18/14, identified the following: Date of incident was 7/18/14, Maltreatment identified was mistreatment. R1 required assist of one for activities of daily living and transfers, and was a high fall risk due to unsteady gait. The report stated on 7/18/14, activity aid overheard R1 state wanted to lay down. Activity aid notified nursing assistant (NA)-Z on that wing who responded to R1 by saying " can't lay down until after lunch." According to the report, activity aid reported the incident to supervisor. The report identified director of nursing and licensed social worker (LSW)-A talked with NA-Z. NA-Z received a written warning for failure to respond to the

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request of R1, and it was learned that NA-Z had already received a verbal warning that week. The report stated LSW-A would visit with " residents of the facility to determine if there are any concerns or complaints relating to" staff member. Although the investigation report included a hand written interview NA-Z, there was no further documented evidence of a comprehensive investigation and any further staff or resident interviews.

Document review of facility care conference report dated 8/11/14, identified R1 "often requests to go back to bed."

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/18/14 incident with NA-Z, had investigated the incident by interviewing NA-Z. When asked what measures were put into place to provide protection to R1and other residents in the facility, LSW-A stated NA-Z received a verbal warning, was educated on resident rights and was moved to another wing to work. LSW-A stated she had interviewed the activity aide and two other nursing assistants that worked that shift. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident.

Although the investigation report included a hand written interview NA-Z, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring the identified staff person to prevent reoccurrence of

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F 225	Continued From page 18 the incident. R6 had diagnosis that included diabetes mellitus and arthritis according to document review of R6's admission Minimum Data Set (MDS), an assessment dated 7/17/14. Document review of the same MDS identified R6 had severe cognitive impairment and required the assistance of two staff for toileting and transfers. Document review of facility resident care plan dated 7/29/14, directed staff R6 had impaired mobility related to generalized weakness, directed staff to assist R6 to ambulate to and from the bathroom with wheeled walker and stand by assist, required physical assistance of one for bed mobility, transfers, ambulation, and wheelchair locomotion, and received physical therapy for strengthening. Review of facility investigation report submitted to Office of Health Facility Complaints dated 7/16/14, identified the following: Date of incident was 7/16/14; Maltreatment identified was mistreatment and neglect. R6 required assist of one for activities of daily living and transfers, and was independent with wheelchair mobility. The report identified on 7/16/14, health unit coordinator (HUC) entered R6's room, R6 requested to use bathroom, and HUC notified a nursing assistant. When HUC returned to R6's room later, R6 was in bed. R6 stated had not been assisted to bathroom, that nursing assistant (NA-Y) came to R6 and said she was too busy, and R6 could go in her pants. HUC assisted R6 to the bathroom and then reported the incident to social services and administrator. The investigation report included hand written	F 225		

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interview from HUC and NA-Y. Although the investigation report included a hand written interview with the NA-Y and HUC involved, there was no further documented evidence of a comprehensive investigation and any other staff or resident interviews.

Document review of facility care conference report dated 7/29/14, identified R6 required assist of one for activities of daily living and transfers, was occasionally incontinent of urine, directed own toileting needs, and at risk for falls related to unsteady gait and fall prior to nursing home.

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/16/14 incident with NA-Y, had investigated the incident by interviewing HUC and one other nursing assistant. When asked what measures were put into place to provide protection to R6 and other residents in the facility, LSW-A stated NA-Y was moved to another wing. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident.

Although the investigation report included a hand written interview with HUC and NA-Y, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-Y to prevent reoccurrence of abuse when moved to another unit who had vulnerable residents.

R12 had diagnosis that included dementia according to document review of the quarterly

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Minimum Data Set (MDS) an assessment dated 5/12/14. Document review of the same MDS identified R12 required extensive assist of two staff for activities of daily living, transfers and toileting and had severe cognitive impairment.

Document review of the facility resident care plan dated 5/27/14, directed R12 had impaired physical mobility related to weakness, gait abnormality, and legal blindness and required assist of one to two staff to reposition, and reposition every three hours. The care plan dated 5/27/14, directed R12 was alert and oriented to self and had short and long term memory impairment. The care plan dated 5/27/14, directed R12 had alteration in elimination, frequently incontinent of bowel and bladder, required extensive assist of two to transfer to and from the toilet with mechanical lift.

Document review of facility investigation report submitted to Office of Health Facility Complaints (OHFC) dated 7/21/14, identified the following: Date of incident was 7/21/14, Maltreatment identified was neglect. R12 was legally blind, required assistance of one staff person for all activities of daily living, required assist of one to two staff for transfers, and at times is transferred with mechanical lift. On 7/21/14, at 6:25 a.m., R12 was found on the floor by bed, blood on the floor from an old elbow hematoma. Director of nursing and administrator determined R12's care plan had not been followed. Document review of the incident details submitted to OHFC dated 7/21/14, revealed cares had not been completed and had not been toileted within the last four hours. Care plan was not followed as R12 was supposed to be toileted every two hours and night shift instructed to complete R12's cares and get

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up for the day, as R12 is restless in the early morning hours and had a history of trying to get out of bed.

Document review of the facility resident incident/fall report dated 7/21/14 revealed R12 found on floor, fall from bed, and old elbow hematoma opened.

Document review of the facility post fall huddle investigation worksheet with date of fall of 7/21/14, revealed R12 did not know what was going on, was last observed in bed, no unusual activities or behaviors, was last toileted at 2:40 a.m., no alarms, no complaints, no environmental issues.

Document review of facility care conference report dated 5/27/14, identified R12 was incontinent of bowel and bladder and staff to anticipate R12's needs.

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/21/14 incident. LSW-A verified R12 was on the care list for night shift to provide cares. She verified NA-X had not provided cares or toileted R12. LSW-A stated she had interviewed NA-X and one other nursing assistant on that shift. LSW-A stated she had educated NA-X on R12's care plan and reminded NA-X to provide cares on last rounds. LSW-A verified no other staff or residents were interviewed.

The facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring

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F 225	Continued From page 22 NA-X to determine compliance in meeting resident needs/treatments to prevent reoccurrence of neglect. R20 had diagnosis that included diabetes mellitus according to document review of the annual Minimum Data Set (MDS) an assessment dated 7/17/14. Document review of the same MDS identified R20 required extensive assist of one to two staff for activities of daily living, extensive assist of one staff for transfers and toileting, and had moderate cognitive impairment. Document review of the facility resident care plan dated 7/29/14, directed R20 had impaired mobility related to right sided weakness, required physical assistance with mobility, transfer with one assist, and one assist getting resident in and out of bed. Document review of facility investigation report submitted to the Office of Health Facility Complaints dated 8/6/13, identified the following: Date of incident was 8/2/13. Maltreatment identified was verbal abuse. R20 required one to two staff assist for transfers. R20 reported to family (F-A) member on 8/6/13, that a nursing assistant (NA-W) had been verbally rude and cursed at R20 when R20 asked for help to stand up. LSW-A, director of nursing and administrator interviewed NA-W. LSW-A interviewed other residents who were on the care list for the NA-W and there were no complaints. Nursing assistant behavior is being monitored by LSW-A, director of nursing and administrator. Document review of facility care conference note dated 8/5/14; identified R20 and family discussed diabetic diet and medications and then had no	F 225		

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F 225	Continued From page 23 further concerns. During telephone interview on 8/20/14 at 9:40 a.m., LSW-A stated she did not remember the incident. LSW-A stated she expected staff to speak respectfully to residents. The facility had no further documented evidence of a comprehensive investigation, no other staff interviewed regarding the staff person, and the facility lacked evidence of monitoring the NA-W to determine compliance and that verbal abuse does not reoccur with NA-W. R25's admission Minimum Data Set (MDS) dated 7/14/14 indicated R25 had a brief interview for mental status (BIMS) of 5, which indicated severe impairment and required extensive assistance of two for bed mobility and toileting, and extensive assistance of one for dressing, eating, and personal hygiene. The care plan dated 7/24/14 indicated R25 was "alert and oriented to person and place. Confusion with time/dates and some short term memory impairments. Able to make simple decisions independently. Requires guidance from family and staff with healthcare decisions." During an interview on 8/11/14 at 4:25 p.m. R25 reported that a nursing assistant came into his room to answer his light about 4:00 a.m. and R25 asked the nursing assistant to turn the hallway light off because it was keeping him up. The nursing assistant told him they had to keep the light on to see to work. R25 stated he told the nursing assistant he would keep putting his call light on until they turned the light off. According to R25 the nursing assistant replied back to him that if he continued to put his call light on that it would "Piss!" her off an in not a nice tone. R25 stated that this happened last week.	F 225		

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F 225	Continued From page 24 During an interview with the licensed social worker (LSW)-A 8/12/14 at 3:30 p.m., the LSW-A stated she was not aware of this incident. On 8/13/14 at 11:00 a.m. during an interview with R25 and LSW-A, R25 stated that it was a female nursing assistant with a pony tail that told him she would get pissed off when he stated he would keep putting his call light on. During an interview with the LSW-A on 8/20/14 at 9:20 a.m., LSW-A verified that she did not interview other staff members or other residents as part of the investigation process when this allegation of verbal abuse was told to her. LSW-A did not indicate or have any documentation they provided any protective measures that had been put into place to prevent reoccurrence of the incident for R25 or any other resident.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their Abuse Prohibition Protocol to immediately report an allegation of abuse to the designated state agency for 1 of 9 residents (R18) reviewed for abuse and neglect; to immediately report an allegation of neglect to the designated state agency for 1 of 9 residents (R68) reviewed for abuse and neglect; and failed	F 226	The staff of Adams Health Care Center will follow the Abuse Prohibition Protocol to immediately report any allegation of abuse and neglect to the designated state agency, will conduct a comprehensive investigation and will provide protection to the residents involved.	9/17/14

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F 226	Continued From page 25 to ensure 7 of 9 residents (R18, R68, R1, R6, R12, R20, R25) reviewed for abuse and neglect incidents were comprehensively investigated and had measures put into place to provide protection. This had the potential to affect all 45 residents in the facility. Findings include: ABUSE PROHIBITION PROTOCOL: Document review of facility Abuse Prohibition Protocol, updated 7/8/14 read, "...Adams Health Care Center's mission is to provide services in a safe and secure living environment, and to maintain the dignity and rights of all persons charged to our care ... Initial reports must be made immediately. Incident reports must be made to the CEP [common entry point] and OHFC [office of heath facility complaints immediately ... Investigation: All reports of alleged abuse, neglect, maltreatment, injuries of unknown source, and/or misappropriation of property shall be promptly and thoroughly investigated by facility management ... (F): in addition the Social Worker will review the resident(s) medical chart, care plan and interview roommates, family members, and visitors who may service as witnesses to the incident, or give information leading up to the incident. Protection: The facility will protect residents from harm during the investigative process. All attempts will be made to maintain the resident's safety, dignity, rights, liberties and sense of well-being during and after the investigation of the incident ... The resident will be free from possible retaliation by the suspected staff members by means of rescheduling or relocating the suspected staff	F 226	The facility policy was reviewed at an All Staff meeting on 09/17/2014. Audits will conducted once per week for a month and once per month for 3 months to monitor for compliance. Social Services Director, DON, Administrator and/or their designee are responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and further recommendation.	

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F 226	Continued From page 26 member, and by monitoring the suspected staff member during his/her presence in the facility ... Definitions Related To The Abuse Protocol ... Abuse- Is conduct (not accidental or therapeutic) that procedures or could produce intentional pain or emotional distress for the VA [vulnerable adult]. This includes; willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, metal anguish or deprivation." AUDITS OF STAFF TREATMENT OF RESIDENTS: During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A stated audits of staff treatment of residents were included in care conference notes and in resident council minutes, if there were any concerns. LSW-A stated the audit was to ask a "general question- are there any concerns with staff or cares?" LSW-A verified there was no other documentation of audits for staff treatment of residents. LSW-A stated staff were educated on resident rights January 2014. If they did not attend, then had to make up the in-service. LSW-A stated she expected staff to speak respectfully to residents. Document review of resident council notes from 1/2014 to 8/2014, revealed no questions regarding staff treatment or cares. Document review of care conference notes 1/1/14 to 8/20/14, revealed no questions or notes regarding staff treatments or cares. The facility lacked documented evidence of audits of staff care and treatment.	F 226		

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F 226	Continued From page 27 STAFF VULNERABLE ADULT TRAINING: Document review of staff training on resident rights and vulnerable adult training conducted on 1-8-14, revealed all staff identified in incident reports received training with the exception of one staff hired 3/14/14, who received the training on 3/14/14. ADMINISTRATOR EXPECTATIONS for a COMPREHENSIVE INVESTIGATION OF AN ALLEGED ABUSE OR NEGLECT INCIDENT: During an interview on 8/20/14 at 2:33 p.m., the administrator stated she expected interviews to be completed with other residents and staff as part of vulnerable adult investigation. The administrator stated she expected staff and resident interviews to documented and kept as part of the investigation and filed in the social service office. The administrator stated the director of nursing, licensed social worker, and administrator completed audits to monitor resident cares and interactions when there was a concern identified with a specific staff member. The administrator verified there was no documentation to show the monitoring or audits had been completed. RESIDENT ALLEGATION OF ABUSE, INVESTIGATION, and PROTECTION: R18's quarterly Minimum Data Set (MDS) dated 7/10/14 revealed R18 had diagnoses of Dementia and Depression. R18 had severe cognitive impairment with clear speech. R32 required	F 226		

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F 226	Continued From page 28 extensive assistance with one staff with dressing, limited assist of one staff for bed mobility, and supervision with one staff for transfers and locomotion. The care plan dated 7/23/14 indicated R18 was, " alert and orientated to person and place ... has some confusion with time and dates. Is able to communicate needs. Is able to make simple decisions independently. " During an interview on 8/12/14, at 11:03 a.m. family (F)-B member stated she was at the facility sometime in July 2014 when R18 voiced a concern to her regarding the remote control for the television not working. FM-B stated she left the facility went home and got new batteries, returned to the facility, placed new batteries in the remote and the remote still did not work. FM-B stated she went to look at the controls and there was a piece of black Velcro tape over the volume control. FM-B stated she alerted staff to this concern and removed the tape from the television. FM-B stated the concerns related to the television and staff approach with R18 were discussed at the care conference held in July of this year. FM-B stated facility staff apologized and stated the incident with R43 ' s television should not have happened. FM-B also stated at care conference when concerns with staff approach was discussed, stated was told by the facility some of their staff have an approach that is " rough around the edges " and he may perceive this as staff not wanting to help him. Stated she was told the facility was working on staff approach on how to speak to residents. The care conference progress noted dated 7/25/14 progress note read, " ...Family then asked about the incident regarding a Velcro adhesive being placed on the volume receptor on	F 226		

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Resident's TV. [F-B] came to visit resident one afternoon and asked why his TV volume was so low. Resident reported that the remote didn't' work, so [F-B] left to go get batteries from home. [F-B] returned and placed them in the remote and states it still did not work. [F-B] then went up to the TV to find a volume control button, at which time [F-B] found the Velcro. [F-B] states [F-B] was caught off guard by this and took the Velcro to a nurse. Social Services informed the [F-B] that this incident had already been brought to the attention of the Administrator, DON, and Social Services and the staff responsible for doing this had been talked to. The [F-B] then stated, " Well I know there are problems with getting [R43] to keep his volume down. I was frustrated when I found it because I had spent so much time trying to fix the remote. ' Social Services assured the [F-B] that this kind of behavior from staff is not allowed and it is considered resident manipulation. Assured [F-B] that this is being monitored so it does not happen again ... "

During an interview on 8/20/14 at 9:40 a.m., the LSW-A verified placing Velcro black tape over the volume control of R43's television would be considered a punishment that resulted in deprivation in R43's ability to use the television in R43's room and would be considered maltreatment/abuse.

LSW-A verified a vulnerable adult report was not made to the designated state agency and stated a report should have been completed. When asked what measures were put into place to provide protection to R43 and other residents in the facility, LSW-A stated the facility was monitoring the staff (nursing assistant [NA]-V) identified in the incident. When asked how the

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facility was monitoring NA-V on the night shift, the LSW-A verified monitoring of NA-V was not being done. LSW-A verified she did not interview other staff members in regard to this incident as a part of the investigation process either. LSW-A also verified there was no documentation of the interviews she completed with residents in the facility neither as a part of the investigation or of the audits completed of the television to ensure Velcro taped had not been placed back over the volume control of R43's television nor if it had occurred to another resident in the facility.

During an interview on 8/20/14 at 2:33 p.m., the administrator stated she thought a vulnerable adult report had been completed for this incident and stated, "Yes, the placing Velcro black tape over the volume control of [R43's] television would be considered a punishment that resulted in deprivation in R43's ability to use the television in R43's room and would be considered maltreatment/abuse. " The administrator stated a vulnerable adult report should have been made and verified the facility did not follow their facility abuse prohibition protocol which included the need to report alleged abuse in this case to the designated state agency.

During an interview on 8/20/14 at 2:33 p.m., the administrator stated she expected comprehensive interviews to be completed with other residents and staff as a part of a vulnerable adult investigation. The administrator stated she expected the staff and resident interviews to be documented and kept as a part of the investigation and filed in the social service office. The administrator stated the director of nursing (DON), LSW-A and the administrator completed ongoing audits to monitor resident cares and

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F 226	Continued From page 31 interactions when there was a concern identified with a specific staff member. The administrator verified there was no documentation to show the monitoring or audits had been completed. ALLEGATION OF NEGLECT, INVESTIGATION and PROTECTION OF RESIDENTS: R68 had diagnosis that included cerebrovascular accident and aphasia according to document review of the admission Minimum Data Set (MDS) an assessment dated 7/2/14. Document review of the same MDS identified R68 required extensive assist of one to two staff for activities of daily living, extensive assist of two staff for transfers and toileting, had short and long term memory problem and moderately impaired decision making. Document review of the facility resident care plan dated 7/15/14, directed R68 had impaired mobility related to cerebrovascular accident, generalized weakness, required physical assistance with transfers and ambulation, unsteady gait and balance. The care plan directed physical assist of one staff for transfers and had history of self-transfers. Document review of facility investigation report submitted to the designated state agency (Office of Health Facility Complaints) dated 7/10/14, identified the following: Date of incident was 7/9/14. Maltreatment identified was neglect. R68 required assist of one staff for activities of daily living and transfers, although R68 had history of transferring self. Maintenance staff found R68 on the floor, reported to licensed wing nurse who responded " I don ' t have time for that. "	F 226		

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Maintenance felt the remark was rude and felt the nurse neglected to respond immediately. LSW-A was notified of the 7/9/14 incident by the director of nursing on 7/10/14. LSW-A interviewed maintenance staff, nurse involved, and one nursing assistant. Review of a hand written note on the OHFC report fax sheet revealed director of nursing was notified on 7/9/14 by maintenance staff and was notified by wing nurse at 8:30 a.m., and " Did not see any discrepancy, because nurse states she was in the room at 8:05 to help resident." Review of director of nursing interview hand written note dated 7/10/14, at 11:45 a.m., revealed the director of nursing received a telephone message about the fall at 10:00 a.m. Director of nursing stated the message was at 8:15 a.m. and stated, " I did not report this to Social Services because there was no discrepancy. The fall occurred at 8:05 am [a.m.] & the nurse had reported it to me by 8:15."

Although maintenance staff indicated the fall incident for R68 was witnessed by the oxygen delivery person, there was no documented evidence that the oxygen delivery person was interviewed regarding the incident.

Document review of facility Resident Incident/Fall Report dated 7/9/14, revealed fall occurred on 7/9/14 at 8:05 a.m., when janitor reported man on the floor. R68 was unable to speak and no medical treatment needed.

Document review of facility care conference note dated 7/15/14, identified R68 and family discussed therapy, plans to return home, stated pleased with care resident received. There were no questions or comments on staff treatment of resident.

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F 226	Continued From page 33 Although the incident occurred on 7/9/14, at 8:05 a.m., the facility did not immediately report the incident of suspected neglect to the designated state agency until 7/10/14, at 11:35 a.m. During telephone interview on 8/20/14, at 9:40 a.m., LSW-A stated she was notified of the incident on 7/10/14. LSW-A stated she expected the nurse to respond immediately. LSW-A stated she interviewed the nurse (licensed nurse [LN-A]) and maintenance staff involved. She stated LN-A reported that she had to lock up medications and then responded to R68 on the floor. LSW-A verified no other staff or residents were interviewed. LSW-A verified the 7/9/14 incident of potential neglect was not immediately reported to the facility or to the designated state agency. During interview on 8/20/14, at 3:03 p.m., the administrator stated she was not aware of the incident of potential neglect until the following day. The facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring LN-A for compliance and to prevent reoccurrence of an incident like the one with R68. Also there was no documentation provided in regards to the protection of R68 during the investigation of the allegation of neglect. R1 had diagnosis that included heart failure and dementia according to document review of R1's admission Minimum Data Set (MDS), an assessment dated 7/24/14. Document review of the same MDS identified R1 had severe cognitive impairment and required the assistance of one	F 226		

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F 226	Continued From page 34 staff for activities of daily living which included toileting and transfers. Document review of facility resident care plan dated 8/11/14, directed staff R1 had impaired mobility related to generalized weakness, and needed physical assistance of one for bed mobility, transfers, ambulation, and wheelchair locomotion. Document review of facility investigation report submitted to the Office of Health Facility Complaints dated 7/18/14, identified the following: Date of incident was 7/18/14, Maltreatment identified was mistreatment. R1 required assist of one for activities of daily living and transfers, and was a high fall risk due to unsteady gait. The report stated on 7/18/14, activity aid overheard R1 state wanted to lay down. Activity aid notified nursing assistant (NA)-Z on that wing who responded to R1 by saying " can't lay down until after lunch." According to the report, activity aid reported the incident to supervisor. The report identified director of nursing and licensed social worker (LSW)-A talked with NA-Z. NA-Z received a written warning for failure to respond to the request of R1, and it was learned that NA-Z had already received a verbal warning that week. The report stated LSW-A would visit with " residents of the facility to determine if there are any concerns or complaints relating to" staff member. Although the investigation report included a hand written interview NA-Z, there was no further documented evidence of a comprehensive investigation and any further staff or resident interviews. Document review of facility care conference report dated 8/11/14, identified R1 "often requests	F 226		

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F 226	Continued From page 35 to go back to bed." During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/18/14 incident with NA-Z, had investigated the incident by interviewing NA-Z. When asked what measures were put into place to provide protection to R1and other residents in the facility, LSW-A stated NA-Z received a verbal warning, was educated on resident rights and was moved to another wing to work. LSW-A stated she had interviewed the activity aide and two other nursing assistants that worked that shift. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident. Although the investigation report included a hand written interview NA-Z, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring the identified staff person to prevent reoccurrence of the incident. R6 had diagnosis that included diabetes mellitus and arthritis according to document review of R6's admission Minimum Data Set (MDS), an assessment dated 7/17/14. Document review of the same MDS identified R6 had severe cognitive impairment and required the assistance of two staff for toileting and transfers. Document review of facility resident care plan dated 7/29/14, directed staff R6 had impaired	F 226		

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mobility related to generalized weakness, directed staff to assist R6 to ambulate to and from the bathroom with wheeled walker and stand by assist, required physical assistance of one for bed mobility, transfers, ambulation, and wheelchair locomotion, and received physical therapy for strengthening.

Review of facility investigation report submitted to Office of Health Facility Complaints dated 7/16/14, identified the following: Date of incident was 7/16/14; Maltreatment identified was mistreatment and neglect. R6 required assist of one for activities of daily living and transfers, and was independent with wheelchair mobility. The report identified on 7/16/14, health unit coordinator (HUC) entered R6's room, R6 requested to use bathroom, and HUC notified a nursing assistant. When HUC returned to R6's room later, R6 was in bed. R6 stated had not been assisted to bathroom, that nursing assistant (NA-Y) came to R6 and said she was too busy, and R6 could go in her pants. HUC assisted R6 to the bathroom and then reported the incident to social services and administrator. The investigation report included hand written interview from HUC and NA-Y. Although the investigation report included a hand written interview with the NA-Y and HUC involved, there was no further documented evidence of a comprehensive investigation and any other staff or resident interviews.

Document review of facility care conference report dated 7/29/14, identified R6 required assist of one for activities of daily living and transfers, was occasionally incontinent of urine, directed own toileting needs, and at risk for falls related to unsteady gait and fall prior to nursing home.

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F 226	Continued From page 37 During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/16/14 incident with NA-Y, had investigated the incident by interviewing HUC and one other nursing assistant. When asked what measures were put into place to provide protection to R6 and other residents in the facility, LSW-A stated NA-Y was moved to another wing. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident. Although the investigation report included a hand written interview with HUC and NA-Y, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-Y to prevent reoccurrence of abuse when moved to another unit who had vulnerable residents. R12 had diagnosis that included dementia according to document review of the quarterly Minimum Data Set (MDS) an assessment dated 5/12/14. Document review of the same MDS identified R12 required extensive assist of two staff for activities of daily living, transfers and toileting and had severe cognitive impairment. Document review of the facility resident care plan dated 5/27/14, directed R12 had impaired physical mobility related to weakness, gait abnormality, and legal blindness and required assist of one to two staff to reposition, and reposition every three hours. The care plan dated 5/27/14, directed R12 was alert and	F 226		

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oriented to self and had short and long term memory impairment. The care plan dated 5/27/14, directed R12 had alteration in elimination, frequently incontinent of bowel and bladder, required extensive assist of two to transfer to and from the toilet with mechanical lift.

Document review of facility investigation report submitted to Office of Health Facility Complaints (OHFC) dated 7/21/14, identified the following: Date of incident was 7/21/14, Maltreatment identified was neglect. R12 was legally blind, required assistance of one staff person for all activities of daily living, required assist of one to two staff for transfers, and at times is transferred with mechanical lift. On 7/21/14, at 6:25 a.m., R12 was found on the floor by bed, blood on the floor from an old elbow hematoma. Director of nursing and administrator determined R12's care plan had not been followed. Document review of the incident details submitted to OHFC dated 7/21/14, revealed cares had not been completed and had not been toileted within the last four hours. Care plan was not followed as R12 was supposed to be toileted every two hours and night shift instructed to complete R12's cares and get up for the day, as R12 is restless in the early morning hours and had a history of trying to get out of bed.

Document review of the facility resident incident/fall report dated 7/21/14 revealed R12 found on floor, fall from bed, and old elbow hematoma opened.

Document review of the facility post fall huddle investigation worksheet with date of fall of 7/21/14, revealed R12 did not know what was going on, was last observed in bed, no unusual

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activities or behaviors, was last toileted at 2:40 a.m., no alarms, no complaints, no environmental issues.

Document review of facility care conference report dated 5/27/14, identified R12 was incontinent of bowel and bladder and staff to anticipate R12's needs.

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/21/14 incident. LSW-A verified R12 was on the care list for night shift to provide cares. She verified NA-X had not provided cares or toileted R12. LSW-A stated she had interviewed NA-X and one other nursing assistant on that shift. LSW-A stated she had educated NA-X on R12's care plan and reminded NA-X to provide cares on last rounds. LSW-A verified no other staff or residents were interviewed.

The facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-X to determine compliance in meeting resident needs/treatments to prevent reoccurrence of neglect.

R20 had diagnosis that included diabetes mellitus according to document review of the annual Minimum Data Set (MDS) an assessment dated 7/17/14. Document review of the same MDS identified R20 required extensive assist of one to two staff for activities of daily living, extensive assist of one staff for transfers and toileting, and had moderate cognitive impairment.

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F 226	Continued From page 40 Document review of the facility resident care plan dated 7/29/14, directed R20 had impaired mobility related to right sided weakness, required physical assistance with mobility, transfer with one assist, and one assist getting resident in and out of bed. Document review of facility investigation report submitted to the Office of Health Facility Complaints dated 8/6/13, identified the following: Date of incident was 8/2/13. Maltreatment identified was verbal abuse. R20 required one to two staff assist for transfers. R20 reported to family (F-A) member on 8/6/13, that a nursing assistant (NA-W) had been verbally rude and cursed at R20 when R20 asked for help to stand up. LSW-A, director of nursing and administrator interviewed NA-W. LSW-A interviewed other residents who were on the care list for the NA-W and there were no complaints. Nursing assistant behavior is being monitored by LSW-A, director of nursing and administrator. Document review of facility care conference note dated 8/5/14; identified R20 and family discussed diabetic diet and medications and then had no further concerns. During telephone interview on 8/20/14 at 9:40 a.m., LSW-A stated she did not remember the incident. LSW-A stated she expected staff to speak respectfully to residents. The facility had no further documented evidence of a comprehensive investigation, no other staff interviewed regarding the staff person, and the facility lacked evidence of monitoring the NA-W to determine compliance and that verbal abuse does not reoccur with NA-W.	F 226		

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F 226	Continued From page 41 R25's admission Minimum Data Set (MDS) dated 7/14/14 indicated R25 had a brief interview for mental status (BIMS) of 5, which indicated severe impairment and required extensive assistance of two for bed mobility and toileting, and extensive assistance of one for dressing, eating, and personal hygiene. The care plan dated 7/24/14 indicated R25 was "alert and oriented to person and place. Confusion with time/dates and some short term memory impairments. Able to make simple decisions independently. Requires guidance from family and staff with healthcare decisions." During an interview on 8/11/14 at 4:25 p.m. R25 reported that a nursing assistant came into his room to answer his light about 4:00 a.m. and R25 asked the nursing assistant to turn the hallway light off because it was keeping him up. The nursing assistant told him they had to keep the light on to see to work. R25 stated he told the nursing assistant he would keep putting his call light on until they turned the light off. According to R25 the nursing assistant replied back to him that if he continued to put his call light on that it would "Piss!" her off an in not a nice tone. R25 stated that this happened last week. During an interview with the licensed social worker (LSW)-A 8/12/14 at 3:30 p.m., the LSW-A stated she was not aware of this incident. On 8/13/14 at 11:00 a.m. during an interview with R25 and LSW-A, R25 stated that it was a female nursing assistant with a pony tail that told him she would get pissed off when he stated he would keep putting his call light on. During an interview with the LSW-A on 8/20/14 at 9:20 a.m., LSW-A verified that she did not interview other staff members or other residents as part of the investigation process when this allegation of verbal abuse was told to her.	F 226		

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F 226	Continued From page 42 LSW-A did not indicate or have any documentation they provided any protective measures that had been put into place to prevent reoccurrence of the incident for R25 or any other resident.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 6 of 9 residents (R18, R1, R6, R12, R20, R25) reviewed for abuse and neglect incidents, were treated with respect and dignity. This had the potential to affect all 45 residents who resided in the facility. Findings include: RESIDENT RIGHTS POLICY: Residents Rights policy dated august 2009 read, " Policy statement: Employees shall treat all residents with kindness, respect, and dignity ... 3. Our facility will make every effort to assist each resident in exercising his/her rights to ensure that the resident is always treated with respect, kindness and dignity." The resident bill of rights dated 7/1/07, read, "Facility must with courtesy promote and care for	F 241	It is the policy of Adams Health Care Center to treat residents with respect and dignity. All residents of Adams Health Care center will be treated as such. A comprehensive investigation will be conducted on all incidents and will be documented. Involved staff will be monitored to determine compliance. Resident Rights Policy and Accidents and Incidents Investigating and Reporting reviewed at an All Staff meeting on 09/17/2014. Random audits will be conducted once per week for one month and once per month for 3 months to monitor for compliance. Social Services Director, DON, Administrator and/or their designee are responsible to monitor for compliance. Results will be forwarded to QA/QI	9/17/14

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F 241	Continued From page 43 you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality." DIRECTOR OF NURSING EXPECTATIONS: During an interview on 8/14/14 at 10:31 a.m., the director of nursing (DON) stated she expected staff to treat residents in the building with respect and dignity. The DON stated education had been completed with staff regarding their approach when interacting and caring for residents. LICENSED SOCIAL WORKER EXPECTATIONS: During telephone interview on 8/20/14 at 9:40 a.m., LSW-A stated she expected staff to speak respectfully to residents. STAFF EDUCATION: Document review of facility abuse prevention training attendance dated 1/8/14, revealed all staff involved in the following incidents received the training and one new hire received training on 3/14/14. R18's quarterly Minimum Data Set (MDS) dated 7/10/14 revealed R18 had diagnoses of Dementia and Depression. R18 had severe cognitive impairment with clear speech. R18 required extensive assistance with one staff with dressing, limited assist of one staff for bed mobility, and supervision with one staff for transfers and locomotion. The care plan dated 7/23/14 indicated R18 was, "alert and orientated to person and place...has some confusion with time and dates. Is able to communicate needs. Is able to make simple decisions independently." During an interview on 8/12/14, at 11:03 a.m. family (F)-B member stated she was at the facility	F 241	Committee for review and further recommendation.	

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F 241	Continued From page 44 sometime in July 2014 when R18 voiced a concern to her regarding the remote control for the television not working. FM-B stated F-B left the facility went home and got new batteries, returned to the facility, placed new batteries in the remote and the remote still did not work. FM-B went to look at the controls on the there was a piece of black Velcro tape over the volume control. F-B then alerted staff to this concern and removed the tape from the television. F-B stated the concerns related to the television and staff approach with R18 were discussed at the care conference held in July of this year. F-B stated facility staff apologized and stated the incident with R18's television should not have happened. F-B also stated at care conference when concerns with staff approach was discussed, stated was told by the facility some of their staff have an approach that is rough around the edges and he may perceive this as staff not wanting to help him. Stated she was told the facility was working on staff approach on how to speak to residents. The care conference progress noted dated 7/25/14 progress note read, "...Family then asked about the incident regarding a Velcro adhesive being placed on the volume receptor on Resident's TV. The [F-B] states [F-B] came to visit resident one afternoon and asked why his TV volume was so low. Resident reported to her that the remote didn't' work, so the [F-B] left to go get batteries from home. [F-B] returned and placed them in the remote and states it still did not work. [F-B] then went up to the TV to find a volume control button, at which time [F-B] found the Velcro. [F-B] states [F-B] was caught off guard by this and took the Velcro to a nurse. Social Services informed the [F-B] that this incident had	F 241		

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already been brought to the attention of the Administrator, DON, and Social Services and the staff responsible for doing this had been talked to. The [F-B] then stated, ' Well I know there are problems with getting him to keep his volume down. I was frustrated when I found it because I had spent so much time trying to fix the remote.' Social Services assured the [F-B] that this kind of behavior from staff is not allowed and it is considered resident manipulation. Assured her that this is being monitored so it does not happen again ..."

During an interview on 8/14/14 at 8:21 a.m., the licensed social worker (LSW)-A verified R18 was not treated with respect and dignity when a facility staff member placed Velcro tape over the volume control on the television.

During an interview on 8/14/14 at 10:31 a.m., the director of nursing (DON) stated she expected staff to treat residents in the building with respect and dignity. The DON verified R18 was not treated with respect and dignity when a facility staff member placed Velcro tape over the volume control on the television. The DON stated education had been completed with staff their approach when interacting and caring for residents.
R1 had diagnosis that included heart failure and dementia according to document review of R1's admission Minimum Data Set (MDS), an assessment dated 7/24/14. Document review of the same MDS identified R1 had severe cognitive impairment and required the assistance of one staff for activities of daily living which included toileting and transfers.

Document review of facility resident care plan

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dated 8/11/14, directed staff R1 had impaired mobility related to generalized weakness, and needed physical assistance of one for bed mobility, transfers, ambulation, and wheelchair locomotion.

Document review of facility investigation report submitted to the Office of Health Facility Complaints dated 7/18/14, identified the following: Date of incident was 7/18/14, Maltreatment identified was mistreatment. R1 required assist of one for activities of daily living and transfers, and was a high fall risk due to unsteady gait. The report stated on 7/18/14, activity aid overheard R1 state wanted to lay down. Activity aid notified nursing assistant (NA)-Z on that wing who responded to R1 by saying " can't lay down until after lunch." According to the report, activity aid reported the incident to supervisor. The report identified director of nursing and licensed social worker (LSW)-A talked with NA-Z. NA-Z received a written warning for failure to respond to the request of R1, and it was learned that NA-Z had already received a verbal warning that week. The report stated LSW-A would visit with " residents of the facility to determine if there are any concerns or complaints relating to" staff member. Although the investigation report included a hand written interview NA-Z, there was no further documented evidence of a comprehensive investigation and any further staff or resident interviews.

Document review of facility care conference report dated 8/11/14, identified R1 "often requests to go back to bed."

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she

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was aware of the 7/18/14 incident with NA-Z, had investigated the incident by interviewing NA-Z. When asked what measures were put into place to provide protection to R1and other residents in the facility, LSW-A stated NA-Z received a verbal warning, was educated on resident rights and was moved to another wing to work. LSW-A stated she had interviewed the activity aide and two other nursing assistants that worked that shift. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident.

Although the investigation report included a hand written interview NA-Z, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring the identified staff person to prevent reoccurrence of the incident.

R6 had diagnosis that included diabetes mellitus and arthritis according to document review of R6's admission Minimum Data Set (MDS), an assessment dated 7/17/14. Document review of the same MDS identified R6 had severe cognitive impairment and required the assistance of two staff for toileting and transfers.

Document review of facility resident care plan dated 7/29/14, directed staff R6 had impaired mobility related to generalized weakness, directed staff to assist R6 to ambulate to and from the bathroom with wheeled walker and stand by assist, required physical assistance of one for

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bed mobility, transfers, ambulation, and wheelchair locomotion, and received physical therapy for strengthening.

Review of facility investigation report submitted to Office of Health Facility Complaints dated 7/16/14, identified the following: Date of incident was 7/16/14; Maltreatment identified was mistreatment and neglect. R6 required assist of one for activities of daily living and transfers, and was independent with wheelchair mobility. The report identified on 7/16/14, health unit coordinator (HUC) entered R6's room, R6 requested to use bathroom, and HUC notified a nursing assistant. When HUC returned to R6's room later, R6 was in bed. R6 stated had not been assisted to bathroom, that nursing assistant (NA-Y) came to R6 and said she was too busy, and R6 could go in her pants. HUC assisted R6 to the bathroom and then reported the incident to social services and administrator. The investigation report included hand written interview from HUC and NA-Y. Although the investigation report included a hand written interview with the NA-Y and HUC involved, there was no further documented evidence of a comprehensive investigation and any other staff or resident interviews.

Document review of facility care conference report dated 7/29/14, identified R6 required assist of one for activities of daily living and transfers, was occasionally incontinent of urine, directed own toileting needs, and at risk for falls related to unsteady gait and fall prior to nursing home.

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/16/14 incident with NA-Y, had

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investigated the incident by interviewing HUC and one other nursing assistant. When asked what measures were put into place to provide protection to R6 and other residents in the facility, LSW-A stated NA-Y was moved to another wing. LSW-A stated documentation of the investigation and staff interviews were located on the incident report. LSW-A verified no other staff or residents were interviewed regarding the incident.

Although the investigation report included a hand written interview with HUC and NA-Y, the facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-Y to prevent reoccurrence of abuse when moved to another unit who had vulnerable residents.

R12 had diagnosis that included dementia according to document review of the quarterly Minimum Data Set (MDS) an assessment dated 5/12/14. Document review of the same MDS identified R12 required extensive assist of two staff for activities of daily living, transfers and toileting and had severe cognitive impairment.

Document review of the facility resident care plan dated 5/27/14, directed R12 had impaired physical mobility related to weakness, gait abnormality, and legal blindness and required assist of one to two staff to reposition, and reposition every three hours. The care plan dated 5/27/14, directed R12 was alert and oriented to self and had short and long term memory impairment. The care plan dated 5/27/14, directed R12 had alteration in elimination, frequently incontinent of bowel and

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F 241	Continued From page 50 bladder, required extensive assist of two to transfer to and from the toilet with mechanical lift. Document review of facility investigation report submitted to Office of Health Facility Complaints (OHFC) dated 7/21/14, identified the following: Date of incident was 7/21/14, Maltreatment identified was neglect. R12 was legally blind, required assistance of one staff person for all activities of daily living, required assist of one to two staff for transfers, and at times is transferred with mechanical lift. On 7/21/14, at 6:25 a.m., R12 was found on the floor by bed, blood on the floor from an old elbow hematoma. Director of nursing and administrator determined R12's care plan had not been followed. Document review of the incident details submitted to OHFC dated 7/21/14, revealed cares had not been completed and had not been toileted within the last four hours. Care plan was not followed as R12 was supposed to be toileted every two hours and night shift instructed to complete R12's cares and get up for the day, as R12 is restless in the early morning hours and had a history of trying to get out of bed. Document review of the facility resident incident/fall report dated 7/21/14 revealed R12 found on floor, fall from bed, and old elbow hematoma opened. Document review of the facility post fall huddle investigation worksheet with date of fall of 7/21/14, revealed R12 did not know what was going on, was last observed in bed, no unusual activities or behaviors, was last toileted at 2:40 a.m., no alarms, no complaints, no environmental issues.	F 241		

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Document review of facility care conference report dated 5/27/14, identified R12 was incontinent of bowel and bladder and staff to anticipate R12's needs.

During telephone interview on 8/20/14, at 9:40 a.m., licensed social worker (LSW)-A verified she was aware of the 7/21/14 incident. LSW-A verified R12 was on the care list for night shift to provide cares. She verified NA-X had not provided cares or toileted R12. LSW-A stated she had interviewed NA-X and one other nursing assistant on that shift. LSW-A stated she had educated NA-X on R12's care plan and reminded NA-X to provide cares on last rounds. LSW-A verified no other staff or residents were interviewed.

The facility had no further documented evidence of a comprehensive investigation, no other staff or resident interviewed regarding the staff person, and the facility lacked evidence of monitoring NA-X to determine compliance in meeting resident needs/treatments to prevent reoccurrence of neglect.

R20 had diagnosis that included diabetes mellitus according to document review of the annual Minimum Data Set (MDS) an assessment dated 7/17/14. Document review of the same MDS identified R20 required extensive assist of one to two staff for activities of daily living, extensive assist of one staff for transfers and toileting, and had moderate cognitive impairment.

Document review of the facility resident care plan dated 7/29/14, directed R20 had impaired mobility related to right sided weakness, required physical assistance with mobility, transfer with

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F 241	Continued From page 52 one assist, and one assist getting resident in and out of bed. Document review of facility investigation report submitted to the Office of Health Facility Complaints dated 8/6/13, identified the following: Date of incident was 8/2/13. Maltreatment identified was verbal abuse. R20 required one to two staff assist for transfers. R20 reported to family (F-A) member on 8/6/13, that a nursing assistant (NA-W) had been verbally rude and cursed at R20 when R20 asked for help to stand up. LSW-A, director of nursing and administrator interviewed NA-W. LSW-A interviewed other residents who were on the care list for the NA-W and there were no complaints. Nursing assistant behavior is being monitored by LSW-A, director of nursing and administrator. Document review of facility care conference note dated 8/5/14; identified R20 and family discussed diabetic diet and medications and then had no further concerns. During telephone interview on 8/20/14 at 9:40 a.m., LSW-A stated she did not remember the incident. LSW-A stated she expected staff to speak respectfully to residents. The facility had no further documented evidence of a comprehensive investigation, no other staff interviewed regarding the staff person, and the facility lacked evidence of monitoring the NA-W to determine compliance and that verbal abuse does not reoccur with NA-W. R25's admission Minimum Data Set (MDS) dated 7/14/14 indicated R25 had a brief interview for mental status (BIMS) of 5, which indicated severe impairment and required extensive assistance of	F 241		

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two for bed mobility and toileting, and extensive assistance of one for dressing, eating, and personal hygiene. The care plan dated 7/24/14 indicated R25 was "alert and oriented to person and place. Confusion with time/dates and some short term memory impairments. Able to make simple decisions independently. Requires guidance from family and staff with healthcare decisions."

During an interview on 8/11/14 at 4:25 p.m. R25 reported that a nursing assistant came into his room to answer his light about 4:00 a.m. and R25 asked the nursing assistant to turn the hallway light off because it was keeping him up. The nursing assistant told him they had to keep the light on to see to work. R25 stated he told the nursing assistant he would keep putting his call light on until they turned the light off. According to R25 the nursing assistant replied back to him that if he continued to put his call light on that it would "Piss!" her off an in not a nice tone. R25 stated that this happened last week.

During an interview with the licensed social worker (LSW)-A 8/12/14 at 3:30 p.m., the LSW-A stated she was not aware of this incident.

On 8/13/14 at 11:00 a.m. during an interview with R25 and LSW-A, R25 stated that it was a female nursing assistant with a pony tail that told him she would get pissed off when he stated he would keep putting his call light on.

During an interview with the LSW-A on 8/20/14 at 9:20 a.m., LSW-A verified that she did not interview other staff members or other residents as part of the investigation process when this allegation of verbal abuse was told to her.

LSW-A did not indicate or have any documentation they provided any protective measures that had been put into place to prevent reoccurrence of the incident for R25 or any other

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F 241	Continued From page 54 resident.	F 241		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/17/14

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F 272	Continued From page 55 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment for elopement for 1 of 1 resident (R43) reviewed for accidents. Findings Include: R43 ' s Medical record review revealed there had been no elopement risk assessments completed even though R43 had a history of elopement/s. R43's admission record identified R43 had diagnoses of bipolar disorder, schizophrenia, obsessive compulsive personality disorder, and history of traumatic brain injury. R43's significant change Minimum Data Set (MDS) dated 5/7/14 indicated R43 had a brief interview for mental status (BIMS) score of 14 indicating no cognitive impairment. Review of incident reports revealed R43 had eloped from the facility on 4/1/14, 4/7/14, 4/8/14, 4/10/14 and 6/3/14. Resident Incident Report dated 4/1/14 indicated R43 had an unwitnessed elopement. At 3:45 p.m., " Resident was ambulating in facility when [R43] pushed the door alarm and went thru the front door of the facility. Staff was able to walk with resident down the front walk way and then returned to the facility after walking with [R43] in the parking lot." Immediate action to prevent further injury to resident: indicated increased	F 272	R43 has not made any attempts to leave the facility grounds since the responsible party (sister) has requested that R43 be allowed to go outside independently since 08/29/2014. R43 is no longer considered an elopement risk and the responsible party concurs with this, however staff will continue to monitor R43's whereabouts to provide supervision and safety. A comprehensive assessment for elopement will be done for all residents of Adams Health Care Center on admission and as needed. The Elopement Risk Policy was reviewed at an All Staff meeting on 09/17/2014. Audits will be conducted on admission and periodically thereafter to monitor for compliance. Social Services, DON, Administrator and/or their designee are responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and further recommendation.	

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monitoring. Prior Mental status: indicated R43 was orientated to person and was forgetful. Plan: "Resident to be in highly visible area. Staff is to go outside with resident for walks when able."

Resident Incident Report dated 4/7/14 indicated R43 had an unwitnessed elopement. At 11:00 a.m., " Resident pushed door alarm and proceeded to go out front door." Immediate action to prevent further injury to resident: was not completed on the incident report. Prior Mental status: indicated R43 was forgetful. Plan: "Staff to assist outside if [R43] wishes." On 8/13/14 at 12:16 p.m. the licensed social worker (LSW)-A verified the incident report did not include, how staff was alerted to R43 being outside, how long R43 was outside, or how R43 was brought back into the facility.

Resident Incident Report dated 4/8/14 indicated R43 had an unwitnessed elopement. At 4:50 p.m., " staff reported resident was outside without w/c [wheelchair] or walker. Had made it to the end of the side walk from the front entrance." Immediate action to prevent further injury to resident: indicated removed to place of safety. "Prior Mental status: indicated R43 was forgetful. Plan: remind resident to ask staff before going outside. On 8/13/14 at 12:16 p.m. LSW-A verified the incident report did not include, how staff was alerted to R43 being outside, how long R43 was outside, or how R43 was brought back into the facility.

Resident Incident Report dated 4/10/14 indicated R43 had an unwitnessed elopement. At 8:20 p.m., " staff noted res [resident] leaving front entrance after the door alarm had sounded. Had walked out by himself and had made it to the

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parking lot." Immediate action to prevent further injury to resident: indicated removed to place of safety. Prior Mental status: indicated R43 was forgetful. Plan: "remind resident to ask to go outside or have staff go outside with resident. IDT [Interdisciplinary team] to meet [with] concerns for safety/elopement, family member (FM)-A would like to see more independence [with] going outside independently. Will update care plan when decision is made by the team."

Resident Incident Report dated 6/3/14/14 at indicated R43 had an unwitnessed elopement. At 7:10 p.m., "Visitor asked this nurse if resident supposed to be outside. Found res [resident] 50 ft. [feet] away from the main entrance, alarm sounding. Res [resident] said, ' I just wanted to circle the block and then come back." Immediate action to prevent further injury to resident: indicated education." Prior Mental status: indicated R43 was orientated to person, forgetful and confused. Plan: "continue to remind [R43] that [R43] needs someone with him when he goes outside."

On 8/14/14 at 9:34 a.m., LSW-A stated, " the facility does not complete elopement assessments for residents. Once a resident leaves the building without telling staff, they are considered a risk for elopement and are added to the wandering book. From there we talk in IDT meetings and determine whether a resident can go outside on their own." LSW-A stated it was " based on staffs' opinion as to whether a resident can be outside unattended and stated she based her opinion on the cognition of the resident."

On 8/14/14 at 10:05 a.m. the director of nursing (DON), " stated an elopement assessment is

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F 272	Continued From page 58 completed on each resident upon admission." The DON verified she was unable to find a completed elopement assessment for R43 in his medical record and stated an elopement assessment had been added on 8/14/14. The DON stated staff should be completing an elopement assessment upon each admission for every resident and verified reassessments should be made to determine if residents risk for elopement had changed during the course of their stay. An Elopement Risk policy dated 3/2011 read as follows: Definition of Elopement Any resident attempting to exit the building without the assistance of family will be determined as attempted elopement. Policy Guidelines The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to implement prevention strategies for those identified as an elopement risk, institute measures for resident identification to be used in the Wandering book at the time of admission, and conduct a missing resident procedure when it is needed. Procedure 1. All entrances to the facility will have an alarm system in place. 2. Staff will be educated on techniques for redirection of residents attempting to elope.	F 272		

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F 272	Continued From page 59 3. Staff will monitor whereabouts of residents at risk for elopement 4. Residents who have been identified as being an elopement risk will have their profile added to the facility wandering book. 5. Residents at risk for elopement will have an elopement care plan in place 6. Staff will complete a missing resident action plan in the event that a resident has eloped from the facility and cannot be located 7. Recurring elopements of residents will be discussed at IDT meeting and interventions will be put in place.	F 272		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to reassess and evaluate fall risk for 1 of 3 residents (R21) reviewed for accidents. Findings include: R21 had been admitted on 4/11/14. R21 ' s quarterly Minimum Data Set (MDS) dated 7/18/14, identified but not limited to diagnoses of dementia, Parkinson ' s disease, heart failure,	F 276	R21 quarterly fall risk assessment was completed on 08/14/2014. All residents of Adams Health Care Center will be assessed, reassessed and evaluated for fall risk. The fall Risk Assessment Policy and the Fall Risk Assessment Observation Form were reviewed at a Licensed Nurses meeting on 09/17/2014.	9/17/14

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F 276	Continued From page 60 chronic obstructive pulmonary disease (COPD) and required extensive assist two persons for transfers. Document review of R21's care plan problem start date 5/30/14, identified problem: at risk for falling related to impaired mobility, requires staff assistance to safely transfer to/from surfaces with interventions of keep call light in reach and place a Dycem gripper under cushion of wheel chair. Document review of R21 ' s resident profile dated 5/30/14 identified but not limited to falls: keep call light in reach. Document review of R21's records identified last completed fall risk evaluation had been dated 4/11/14, and identified a score of 20 (a resident who scores a 10 or higher is at risk). Reassessment of R21 ' s fall risk had not been completed for R21 ' s quarterly review MDS dated 7/18/14. Further review of R21 ' s record identified R21 had a fall on 8/11/14. During interview on 8/14/14, at 1:30 p.m., registered nurse (RN)-D verified a fall risk assessment had not been completed for R21's quarterly review dated 7/18/14 and last fall risk assessment completed had been dated 4/11/14. During interview on 8/14/14, at 1:25 p.m., director of nursing had stated she would expect a quarterly fall risk assessment to be completed for R21. Policy for fall risk assessment requested at the time and director of nursing had stated we have no policy regarding quarterly fall risk assessment.	F 276	Audits will be conducted periodically at admission, quarterly and randomly to monitor for compliance. DON, SD, MDS Coordinator are responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and further recommendation.	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		9/17/14

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F 282 SS=D	Continued From page 61 PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for oxygen administration for 1 of 3 residents (R21) reviewed for respiratory care; failed to follow the care plan for nail care for 1 of 3 residents (R21) reviewed for activities of daily living; failed to follow the care plan for fall interventions for 1 of 3 residents (R21) reviewed for accidents and failed to follow the care plan for skin for 2 of 3 residents (R21, R12) reviewed for skin conditions. Findings include: R21 had been admitted on 4/11/14 according to R21's quarterly Minimum Data Set (MDS) dated 7/18/14, identified but not limited to diagnoses of dementia, Parkinson ' s disease, heart failure and chronic obstructive pulmonary disease (COPD). R21's physician orders dated 7/16/14, identified order oxygen two liters via nasal cannula to keep oxygen saturation equal to or less than 90 percent. During observation on 8/11/14, at 6:58 p.m., R21 had been in room sitting in wheelchair, a portable oxygen unit had been hanging on the back of R21 ' s wheelchair and R21 ' s oxygen nasal cannula had been connected to the tank containing liquid oxygen set at two liters and the scale on top of	F 282	All care plans will be followed for all residents of Adams Health Care Center. An inservice education was held on 09/17/2014 to review the process of following care plans for all residents. Audits will be conducted once per week for one month and once per month for 3 months to monitor for compliance. DON, SD, MDS Coordinator are responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and further recommendation.	

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F 282	Continued From page 62 the unit read empty for amount of oxygen remaining. R21 ' s call light had not been in reach of R21 and had been wrapped in a blanket on R21 ' s bed and the end of the call light had not been visible. R21's fingernails on bilateral hands had been long with black debris observed underneath all fingernails and R21 had a bruise on top of left hand between thumb and first finger. R21 had stated at the time he had no difficulty breathing. Surveyor alerted staff and nursing assistant (NA)-E at the time verified R21's call light was not in reach for R21 and R21's portable oxygen unit tank read empty. NA-E then disconnected R21's nasal cannula tubing from R21 ' s portable tank, re-connected the tubing to a standing tank of liquid oxygen in R21's room, set the dial at three liters on the standing oxygen tank and then NA-E walked out of R21's room. Surveyor interviewed at the time and asked NA-E how knows how many liters oxygen R 21 was to be receiving and NA-E had stated it is on R21's care plan in the computer. NA-E showed surveyor R21's care plan in the computer and R21's care plan read R21 was to be receiving oxygen at two liters. NA-E verified had set R21's oxygen at three liters and went back into R21's room and changed the dial to 2 liters on R21's standing liquid oxygen tank. During observation 8/13/14, at 11:17 a.m., R21 had been sitting in room in wheelchair and had a bruise on top of left hand between thumb and first finger, purple in color. R21's fingernails on bilateral hands remained long with black debris observed underneath all nails. During observation on 8/13/14, at 3:25 p.m., nursing assistant (NA)-J verified R21 ' s fingernails on bilateral hands were long, black	F 282		

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debris was underneath all fingernails and had a bruise on top of left hand between thumb and first finger. NA-J had stated fingernails and toenails are to be trimmed and cleaned underneath on bath days, should be documented on bath sheets when done, and when a resident refuses to let nurse know. NA-J verified at the time R21 ' s bath day had been on 8/12/14, and R21 ' s bath sheets dated 8/12/14, 7/30/14, 7/25/14, 7/18/147/11/14, 7/4/14 and 6/20/14 had no documentation nail care had been done.

On 8/14/14, at 3:14 p.m., registered nurse (RN)-A verified R21 had a bruise on top of left hand between thumb and first finger and at the time RN-A measured the bruise to be 2.5 cm (centimeters) by 2.5 cm and in addition at the time R21 had a bruise on the right hand middle finger, dark purple in color measuring 1.2 cm by .6 cm and a bruise on right wrist dark purple in color measuring 1.5 cm by 1.3 cm. RN-A verified at the time R21 ' s body audit forms dated 6/2014, 7/4/14, 7/11/14, 7/18/14, 7/25/14, 7/30/14 and 8/12/14 had no documentation of skin problems or bruising.

R21 ' s care plan problem start date 5/30/14, identified category skin: alteration in skin integrity with approaches of but not limited to licensed nurse to assess skin weekly and document any findings on bath book and observe skin daily with care, report abnormal finding to nurse such as ulcers, bruising, skin tears, redness over bony prominence. Problem: at risk for hypoxia related to COPD and congestive heart failure with interventions of but not limited to administer oxygen at two liters via nasal cannula as needed to keep oxygen saturation at 90 percent. Problem: self-care deficit related to generalized

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weakness with interventions of but not limited to check fingernails each shift with cares for dried BM (bowel movement) and clean/clip as needed, physical assist of one to two with grooming/hygiene, weekly bath, nail care to be done after bath and as needed. Problem: at risk for falling related to impaired mobility, requires staff assistance to transfer to/from surfaces with interventions of but not limited to keep call light in reach.

R21 ' s resident profile identified but not limited to clinical monitoring skin dated 5/30/14, observe skin daily with care, report abnormal finding, clinical monitoring: administer oxygen at two liters via nasal cannula as needed, falls: keep call light in reach and behavioral symptoms: staff must check resident ' s nails daily.

Document review of R21 ' s body audit forms dated 6/20/14, 7/4/14, 7/11/14, 7/18/14, 7/25/14, 7/30/14 and 8/12/14 had no documentation of skin problems, bruising or nail care. No nurse signature had been documented on R21 ' s body audit forms for the weeks of 6/20/14, 6/27/14, 7/11/14, 7/25/14 and 7/30/14, to verify a licensed nurse had completed an assessment of skin weekly and no body audit forms had been completed for R21 the weeks of 6/27/14 and 8/8/14.

Document review of R21 ' s progress notes dated 6/18/14, at 10:09 a.m., through 8/14/14, at 3:35 p.m., had no documentation of weekly skin assessments being completed by a nurse or of bruising. No documentation had been in R21 ' s record regarding the three bruises R21 had until after surveyor had RN-A verify bruising on 8/14/14, at 3:14 p.m. RN-A had then documented

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in R21 ' s progress note on 8/14/14, at 5:24 p.m., regarding the three bruises.

During interview on 8/14/14, at 4:03 p.m., director of nursing (DON) had stated in regards to R21 ' s bruises, she would expect bruises to be identified and reported and to monitor bruises weekly with bath after identified. DON had stated she would expect call light to be in reach, fingernails to be trimmed and cleaned weekly with bath, follow what orders are for oxygen liters to be set at and should check profile first if do not know what setting oxygen is to be on. Administrator at the time verified the same.

During interview on 8/20/14, at 9:15 a.m., with administrator and registered nurse (RN)-D, administrator had stated everybody gets a weekly bath, and verified R21 had no body audit completed for weeks of 6/27/14 and 8/8/14. Administrator verified R21 ' s body audit forms had no nurse signatures for the dates of 6/20/14, 7/11/14, 7/25/14 and 7/30/14. Administrator verified bruises were not identified on R21 ' s body audit form dated 8/12/14. Administrator had stated R21 had a fall on 8/11/14 and verified bruises had not been identified on R21 ' s incident fall report. Administrator stated the facility monitors for signs of bruising for three days after a fall and provided medication administration history dated 8/11/14 through 8/19/14, identifying monitor for signs of bruising after the fall times three days for three times a day for dates of 8/12/14 through 8/15/14. RN-A verified although staff had initialed that they monitored for bruises, no bruises had been noted or identified for the four days. Administrator had stated staff should have identified bruises " if there were bruises there. " Administrator had stated she expected

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F 282	Continued From page 66 when staff find a bruise that they immediately report to nurse, nurse completes incident report, if cause unknown then report to OHFC (Office of Health Facility Complaints) if cause is known then do incident report but do not report to OHFC. Administrator had stated she would expect body audit form sheets to be completed for each bath, she expected nurse to complete body audits and sign the audit forms and she expected the bruises to be identified " if they exist " with the body audits. Administrator verified R21 ' s care plan read, " Licensed nurse to assess skin weekly and document any findings on bath book. " Administrator verified bath book is the facility body audit form and verified R21 ' s care plan read, " Observe skin daily with care report abnormal finding to nurse such as ulcers, bruising, skin tears, redness over bony prominence, etc. " Administrator had stated she expected staff to follow the care plan and verified the care plan had not been followed. Document review of the facility OXYGEN ADMINISTRATION undated, read " POLICY Oxygen administration will be carried out only with a physician ' s order. A licensed nurse or other staff person trained in the use of oxygen will be on duty and be responsible for the correct administration of oxygen to the resident. " R12 had been admitted on 1/12/11. R12 ' s admission record dated 8/14//14, identified but not limited to diagnoses of dementia and anxiety. During observation on 8/11/14, at 6:55 p.m., R12 had Geri sleeves on bilateral lower arms/hands, a purple bruise had been visible on left hand by thumb and a purple bruise had been visible by thumb on right hand.	F 282		

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F 282	Continued From page 67 During observation on 8/13/14, at 11:21 a.m., R12 had been sitting in wheelchair in activity room doing exercises, Geri sleeves had been on bilateral lower arms/hands and bruising noted the same. During observation on 8/14/14, at 8:19 a.m., R12 had been transferred by nursing assistant (NA)-K and nursing assistant (NA)-L from bed into bathroom, onto toilet, from toilet into wheelchair using a stand lift (no bumping of R12 ' s arms or hands had been observed by surveyor during transfer). R12 had Geri-sleeves on bilateral lower arms/hands and a purple bruise had been visible on left hand by thumb and a purple bruise had been visible by thumb on right hand. On 8/14/14, at 3:14 p.m., registered nurse (RN)-A verified R12 had a bruise on left hand by thumb and a bruise by thumb on right hand and at the time RN-A measured the bruise on top of left hand by thumb to be 3 cm by 3 cm (dark purple in color) and the bruise on right hand by thumb to be 3 cm by 2 cm (purple in color). R12 ' s family member-C had been present at the time and had removed R12 ' s Geri sleeves from R12 ' s bilateral lower arms/hands and additional bruising on bilateral hands and lower arms had been visible. RN-A at the time measured the following: right elbow a dark purple bruise 3.5 cm by 3.5 cm, right below that two dark purple bruises measuring 2.5 cm by 1 cm and 1.5 cm by 1 cm, on top of right forearm dark purple bruise 3 cm x 4 cm and medium red color bruise 1 cm by 2.5 cm, right wrist dark purple 1.5 cm by 1.8 cm, on top of right hand purple bruise between fourth and fifth finger 4.5 cm by 1.5 cm, left hand under fifth finger two dark purple bruises measured 1.5	F 282		

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F 282	Continued From page 68 cm by 1.2 cm and .75 cm x .5 cm, left wrist fading purple bruise 1.5 cm by 2 cm, on left forearm: purple bruise 1.5 cm by 1 cm, dark purple bruise .75 cm by 1 cm, fading purple bruise .5 cm by 2 cm, fading purple 3 cm by 5.75 cm, fading purple 1.5 cm by 1.5 cm, left wrist fading purple bruise 1.5 cm by 2 cm and on outer side of left forearm a skin tear measuring 1 cm by 1.5 cm surrounded by bruising 3 cm by 4 cm. R12 ' s care plan problem start date 5/27/2014, category skin identified at risk for developing skin breakdown related to but not limited to skin fragile, receives bruises easily as bumps into things while wheeling self and/or reaching out for things or when becomes physically abusive towards staff with approaches of but not limited to: Geri sleeves bilaterally except for cares, be careful when removing Geri-sleeves and clothing, observe skin daily with cares in am and pm, report to nurse any issues and weekly skin inspections by a nurse. Document review of R12 ' s body audit forms dated 6/10/14, 6/17/14, 6/24/14, 7/8/14, 7/125/14, 7/22/14 and 7/28/14 had no documentation of skin problems or bruising. No nurse signature had been documented on R12 ' s body audit forms for the weeks of 6/10/14, 6/24/14, 7/8/14 and 7/15/14, to verify a licensed nurse had completed an inspection of skin weekly and no body audit forms had been completed for R12 the weeks of 7/1/14, 8/4/14 and 8/11/14. On 8/14/14, at 3:40 p.m., RN-A had provided surveyor documentation R12 had received a bath on 8/4/14, printed from the facilities point of care history, however there had been no documentation a skin assessment had been completed by a nurse or of bruising.	F 282		

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Document review of R12 ' s progress notes dated 6/10/14, at 12:04 p.m., through 8/12/14, at 1:40 p.m., had no documentation of weekly skin assessments being completed by a nurse or of bruising other than on 7/21/14, at 10:23 a.m., right elbow old hematoma two cm diameter open. No documentation had been in R12 ' s record regarding the bruises as described above until after surveyor had RN-A verify bruising on 8/14/14, at 3:14 p.m. RN-A had then documented in R12 ' s progress note on 8/14/14, at 4:48 p.m., regarding the bruises as described above.

During interview on 8/14/14, at 2:47 p.m., licensed practical nurse (LPN)-A had stated if bath sheet completed after 7/28/14, would be located in the bath book only. LPN-A verified R12 ' s nurse progress notes had no documentation regarding bruising on either of R12 ' s hands and nothing had been documented in the orders of R12 where monitoring of bruising would be set up.

During interview on 8/14/14, at 3:23 p.m., RN-A verified R12 ' s body audit forms dated 6/10/14, 6/17/14, 6/24/14, 7/8/14, 7/15/14, 7/22/14 and 7/28/14, had no documentation of skin problems or bruising.
During interview on 8/14/14, at 4:03 p.m., director of nursing had stated in regards to R12 ' s bruises, she would expect bruises to be identified and reported and to monitor bruises weekly with bath after identified. Administrator at the time verified the same.

During interview on 8/20/14, at 9:15 a.m., with administrator and registered nurse (RN)-D, administrator had verified no body audit forms had been completed for R12 on 7/1/14, 8/4/14

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and 8/11/14. Administrator had stated she expected skin assessments were the body audit forms, were to be completed weekly and that the nurse reviewed the body audit forms and signed the body audit forms weekly. Administrator had verified there had been no nurse signatures on R12 ' s body audit forms dated 6/10/14, 6/24/14, 7/8/14 and 7/15/14. Administrator had stated R12 had had a weekly bath, although verified lack of body audit forms and lack of weekly skin assessment as above. Administrator had stated the body audit forms signed by the nurse were the weekly nurse skin assessments.
Administrator had stated she expected nursing assistants to document am and pm in point of care any skin concerns. Administrator had stated she expected body audit sheets to be completed for each bath and expected a nurse to complete a body audit and sign the body audit forms.
Administrator had stated she expected the bruises to be identified " if they exist " with the body audits. Administrator had verified R12 ' s care plan read, " Observe skin daily with cares in am and pm. Report to nurse any issues " and " Weekly skin inspections by a nurse. "
Administrator had stated she expected staff to follow the care plan and verified the care plan had not been followed.
Document review of the facility BODY AUDIT POLICY AND PROCEDURE dated 2007, read "POLICY: To be completed for all residents for identification of alterations in skin integrity. PROCEDURE: 1. On resident bath/shower day, obtain Body Audit form. 3. The Nursing Assistant is to obtain the weight, vital signs, indicates type of bath/shower and nail care if appropriate. Then the Nursing assistant is to contact the Licensed Nurse for the skin inspection and pain assessment. 4. The licensed Nurse is to explain

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F 282	Continued From page 71 the procedure of the skin inspection. 5. The Licensed Nurse completes a head to toe inspection of the skin with notation of any alterations in skin condition on the Body Audit form. The Licensed Nurse is also to assess for any pain concerns and note them. 6. The Licensed Nurse and Nursing Assistant signs the form. The Licensed Nurse proceeds forward per policy if a change in the resident ' s skin condition and/or pain is noted. 7. Communicate to Interdisciplinary Team, Physician/NP and Family any changes in skin integrity or pain concerns. 8. Update resident care plan and nursing assistant assignment sheets as needed. " During interview on 8/14/14, at 4:03 p.m., policy regarding following the care plan had been requested from the director of nursing, none had been provided.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure clean and trimmed nails for 1 of 3 residents (R21) reviewed for activities of daily living. Findings include: R21 had been admitted on 4/11/14. R21 ' s	F 312	R21's nails were cleaned and trimmed on 08/13/2014 and will continue to be clean and trimmed. Nursing staff will ensure that nails are clean and trimmed for all residents of Adams Health Care Center on a daily basis. Nail care reviewed at a nursing	9/17/14

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F 312	Continued From page 72 quarterly Minimum Data Set (MDS) dated 7/18/14, identified but not limited to diagnoses of dementia, Parkinson ' s disease, heart failure, chronic obstructive pulmonary disease (COPD) and required extensive assist of one person for personal hygiene. During observation on 8/11/14, at 6:58 p.m., R21 had been in room sitting in wheelchair. R21 ' s fingernails on bilateral hands had been long with black debris observed underneath all fingernails. During observation 8/13/14, at 11:17 a.m., R21 had been sitting in room in wheelchair and R21 ' s fingernails on bilateral hands remained long with black debris observed underneath all nails. During observation on 8/13/14, at 3:25 p.m., nursing assistant (NA)-J verified R21 ' s fingernails on bilateral hands were long and black debris was underneath all fingernails. NA-J had stated fingernails and toenails are to be trimmed and cleaned underneath on bath days, should be documented on bath sheets when done, and when a resident refuses to let nurse know. NA-J verified at the time R21 ' s bath day had been on 8/12/14, and R21 ' s bath sheets dated 8/12/14, 7/30/14, 7/25/14, 7/18/147/11/14, 7/4/14 and 6/20/14 had no documentation nail care had been done. R21 ' s care plan problem start date 5/30/14, identified problem: self-care deficit related to generalized weakness with interventions of but not limited to check fingernails each shift with cares for dried BM (bowel movement) and clean/clip as needed, physical assist of one to two with grooming/hygiene, weekly bath, nail care to be done after bath and as needed.	F 312	department meeting on 09/17/2014. Random audits will be conducted daily, on bath day, periodically and as needed to check for clean and trimmed nails. DON, SD/IC and/or their designee are responsible to monitor for compliance. Results will be for and continue to forwarded to QA/QI Committee for review and further recommendation.	

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F 312	Continued From page 73 R21 ' s resident profile identified but not limited to ADL (activities of daily living) functional/rehabilitation potential: physical assist of one to two with grooming/hygiene and behavioral symptoms: staff must check resident ' s nails daily. Document review of R21 ' s body audit forms dated 6/20/14, 7/4/14, 7/11/14, 7/18/14, 7/25/14, 7/30/14 and 8/12/14 had no documentation of nail care. During interview on 8/14/14, at 4:03 p.m., director of nursing (DON) had stated she would expect fingernails to be trimmed and cleaned weekly with bath. Administrator at the time verified the same. Policy for nail care had been requested at the time, none had been provided.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to appropriately assess the risk for elopement and implement interventions to provide supervision and safety for 1 of 1 resident (R43) who had eloped from the facility.	F 323	R43 has not made any attempts to leave the facility grounds since the responsible party (sister) has requested that R43 be allowed to go outside independently on 08/29/2014. R43 is no longer considered	9/17/14

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F 323	Continued From page 74 Findings Include: R43's admission record identified R43 had diagnoses of bipolar disorder, schizophrenia, obsessive compulsive personality disorder, and history of traumatic brain injury. R43's significant change Minimum Data Set (MDS) dated 5/7/14 indicated R43 had a brief interview for mental status (BIMS) score of 14 indicating no cognitive impairment. Review of incident reports revealed R43 had eloped from the facility on 4/1/14, 4/7/14, 4/8/14, 4/10/14 and 6/3/14. Resident Incident Report dated 4/1/14 indicated R43 had an unwitnessed elopement. At 3:45 p.m., "Resident was ambulating in facility when [R43] pushed the door alarm and went thru the front door of the facility. Staff was able to walk with resident down the front walk way and then returned to the facility after walking with [R43] in the parking lot." Immediate action to prevent further injury to resident: indicated increased monitoring. Prior Mental status: indicated R43 was orientated to person and was forgetful. Plan: "Resident to be in highly visible area. Staff is to go outside with resident for walks when able." Resident Incident Report dated 4/7/14 indicated R43 had an unwitnessed elopement. At 11:00 a.m., "Resident pushed door alarm and proceeded to go out front door." Immediate action to prevent further injury to resident: was not completed on the incident report. Prior Mental status: indicated R43 was forgetful. Plan: "Staff to assist outside if [R43] wishes." On 8/13/14 at 12:16 p.m. the licensed social worker (LSW)-A	F 323	an elopement risk and responsible party concurs with this however staff will continue to monitor R43's whereabouts to provide safety and supervision.. All residents of Adams Health Care Center will be assessed for elopement risk at admission and as needed and interventions will be implemented to provide supervision and safety. Elopement risk assessment policy reviewed at an All Staff meeting on 09/17/2014. Random audits will be conducted at admission and periodically as needed. Social Services Director, DON and/or their designee are responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and further recommendation.	

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verified the incident report did not include, how staff was alerted to R43 being outside, how long R43 was outside, or how R43 was brought back into the facility.

Resident Incident Report dated 4/8/14 indicated R43 had an unwitnessed elopement. At 4:50 p.m., "staff reported resident was outside without w/c [wheelchair] or walker. Had made it to the end of the side walk from the front entrance." Immediate action to prevent further injury to resident: indicated removed to place of safety." Prior Mental status: indicated R43 was forgetful. Plan: remind resident to ask staff before going outside. On 8/13/14 at 12:16 p.m. LSW-A verified the incident report did not include, how staff was alerted to R43 being outside, how long R43 was outside, or how R43 was brought back into the facility.

Resident Incident Report dated 4/10/14 indicated R43 had an unwitnessed elopement. At 8:20 p.m., "staff noted res [resident] leaving front entrance after the door alarm had sounded. Had walked out by himself and had made it to the parking lot." Immediate action to prevent further injury to resident: indicated removed to place of safety. Prior Mental status: indicated R43 was forgetful. Plan: "remind resident to ask to go outside or have staff go outside with resident. IDT [Interdisciplinary team] to meet [with] concerns for safety/elopement, family member (FM)-A would like to see more independence [with] going outside independently. Will update care plan when decision is made by the team. "

Resident Incident Report dated 6/3/14/14 at indicated R43 had an unwitnessed elopement. At 7:10 p.m., "Visitor asked this nurse if resident

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ADAMS HEALTH CARE CENTER	810 WEST MAIN STREET ADAMS, MN 55909

(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 323	Continued From page 76 suppose to be outside. Found res [resident] 50 ft. [feet] away from the main entrance, alarm sounding. Res [resident] said, 'I just wanted to circle the block and then come back." Immediate action to prevent further injury to resident: indicated education." Prior Mental status: indicated R43 was orientated to person, forgetful and confused. Plan: "continue to remind [R43] that [R43] needs someone with him when he goes outside." R43's care plan dated 5/0/14, identified R43 was an, "elopement risk r/t [related to] impulsive behavior wants to go outside and will forget to ask staff to accompany him. Is aware to push button as observed pushing the front door button however other times have went out and doors alarmed." The care plan further identified a goal that R43 "will ask staff to accompany him outside each time through the next review." The care plan listed interventions including: Resident added to facility Wandering Book. Staff to monitor whereabouts, remind resident to ask for assistance when wishes to go outside, staff to be aware of resident's location when up ambulating and is near front entrance. Educate need for walker and assistance when ambulating at all times in/outside. In addition R43's care plan dated 5/8/14, identified R43 was, "alert and oriented x 3 [to person, place and time]. Able to make needs known. Some short and long term memory impairments present. He is forgetful and becomes confused d/t [due to] brain injury. The care plan further identified a goal that R43 "will maintain current cognitive abilities and show no decline through next review." The care plan listed interventions including: Allow resident to make independent decisions as often as possible.	F 323		

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Assist as needed. Give resident plenty of time to process what is being said or asked. R43 can often come up with an answer on R43's own if R43 is not rushed. Offer reminders as needed. Check for understanding by using 'yes' or 'no' questions. Point out clocks and calendars to assist resident with orientation to time/dates.

On 8/13/14 at 12:16 p.m. LSW-A stated R43 had a traumatic brain injury (TBI), poor memory and was not going to remember to ask for assistance to go outside. LSW-A verified the intervention of reminding R43 to ask staff to go outside that was put into place to prevent reoccurrence of residents' repeated elopements would not be effective due to R43's TBI and poor memory.

On 8/14/14 at 9:34 a.m., LSW-A stated, "the facility does not complete elopement assessments for residents. Once a resident leaves the building without telling staff, they are considered a risk for elopement and are added to the wandering book. From there we talk in IDT meetings and determine whether a resident can go outside on their own." LSW-A stated it was "based on staffs' opinion as to whether a resident can be outside unattended and stated she based her opinion on the cognition of the resident." LSW-A stated she was on maternity leave during the period of elopements for R43 and verified the wandering book had not been updated to include R43. LSW-A verified the facility did not follow their Elopement Risk Policy and Procedure for R43.

On 8/14/14 at 10:05 a.m. the director of nursing (DON), stated, "An elopement assessment is completed on each resident upon admission." The DON verified she was unable to find a completed elopement assessment for R43 in his

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medical record and stated an elopement assessment had been added on 8/14/14. The DON stated staff should be completing an elopement assessment upon each admission for every resident and verified reassessments should be made to determine if residents risk for elopement had changed during the course of their stay. The DON verified the wandering book should have been updated to reflect R43 was at risk for elopement.

An Elopement Risk policy dated 3/2011 read as follows:

Definition of Elopement
Any resident attempting to exit the building without the assistance of family will be determined as attempted elopement.

Policy Guidelines

The facility strives to promote resident safety and protect the rights and dignity of the residents. The facility maintains a process to implement prevention strategies for those identified as an elopement risk, institute measures for resident identification to be used in the Wandering book at the time of admission, and conduct a missing resident procedure when it is needed.

Procedure

1. All entrances to the facility will have an alarm system in place.

2. Staff will be educated on techniques for redirection of residents attempting to elope.

3. Staff will monitor whereabouts of residents at

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F 323	Continued From page 79 risk for elopement 4. Residents who have been identified as being an elopement risk will have their profile added to the facility wandering book. 5. Residents at risk for elopement will have an elopement care plan in place 6. Staff will complete a missing resident action plan in the event that a resident has eloped from the facility and cannot be located 7. Recurring elopements of residents will be discussed at IDT meeting and interventions will be put in place. Although R43 had eloped on 4/1/14, 4/7/14, 4/8/14, 4/10/14 and 6/3/14 the facility failed to comprehensively assess and reassess R43 ' s elopement risk to determine and implement appropriate interventions to ensure R43 received adequate supervision to prevent potential accidents.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a medication error rate of less than 5% for 2 of 7 residents (R3, R61) observed during the medication	F 332	All medications will be administered per physician's orders and per Adams Health Care Center Medication Procedure.	9/17/14

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F 332	Continued From page 80 administration observation. The facility had a medication error rate of 13.79%. Findings include: R3 was observed during medication administration on 8/11/14, at 5:35 p.m. observation of gastric tube (GT) medication administration. During preparation, registered nurse (RN)-C took each medication and mixed them all together in a drinking cup. The medications were lactulose solution 5 ml (milliliter) (a synthetic sugar used to treat constipation), metoprolol tartrate 12.5 mg (milligrams) (a heart medication) and simvastatin 10 mg (a cholesterol lowering drug). The tablets were all crushed and placed in with the liquid medication and 120 cc (cubic centimeters) of water. After mixing all medications together with water and checking placement of the GT RN-C attached the syringe to the GT and pushed in the medications. R3's gastrostomy tube (GT) had not been flushed with the prescribed amount of water before and after medication administration and all medications were mixed together and given at once. RN-C verified at the time and had stated, " water is just given with the pills, not before and after medications, we flush with water every four hours 60 cc before and after feeding and meds, I do it the unconventional way, you are probably going to tell me I did it wrong, no other flushes other than every four hours before and after feeding and meds, none between meds. " Document review of R3 ' s physician orders dated 6/24/14, identified order flush J-tube (jejunostomy tube) with 60 cc of water before and after feeding and meds, six times per day.	F 332	Medication Procedure and Feeding Tube Policy reviewed at a Nursing Department meeting on 09/17/2014 to ensure that medications are accurately administered. Audits will be conducted once per week for one month and once per month for 3 months to monitor for compliance. DON, SD and/or their designee are responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and further recommendation.	

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F 332	Continued From page 81 Document review of R3 ' s medication administration history dated 8/1/14 through 8/13/14, identified flush check every four hours, flush J-tube with 60 cc of water before and after feeding and meds, six times per day. During interview on 8/13/14, at 3:04 p.m., director of nursing had stated would expect water flush to be done before and after medications administered as ordered. Document review of the facility FEEDING TUBE POLICY AND PROCEDURE dated 6/5/10, read "OTHER MEMBERS OF THE INTERDISCIPLINARY Flush tube BEFORE and AFTER Meds per MD order" R61 was observed during medication administration on 8/14/14, at 7:53 a.m., licensed practical nurse (LPN)-E was observed to prepare medications for R61 and had placed one tab of vitamin D3 1,000 unit into a medication cup (which contained R61 ' s other oral medications) and then LPN-E had administered the medications to R61. Document review of R61 ' s physician orders dated 6/18/14, identified order for vitamin D3 1,000 unit two tablets by mouth one time daily. Document review of R61 ' s medication administration history dated 8/1/14 through 8/14/14, identified vitamin D3 1,000 unit two tablets by mouth one time daily. During interview on 8/14/14, at 9:13 a.m., LPN-E verified R61 ' s physician orders dated 6/18/14 read vitamin D3 1,000 unit two tablets by mouth one time daily. LPN-E verified had given R61 one	F 332		

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F 332	Continued From page 82 tablet of Vitamin D3 at time of medication administration and not two tablets as ordered. During interview on 8/14/14, at 3:49 p.m., director of nursing had stated would expect too look at order before giving vitamin D3 to assure correct dose had been given. Document review of the facility Adams Health Care Center Medication Procedure dated revised 5/10/10, read " 4. Before administering medication, the resident must be identified, checking the MAR and the card or bottle to ensure accurate administration. "	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		9/17/14

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F 431	Continued From page 83 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to ensure accurate medication labels for 2 of 15 medication labels reviewed for 1 of 7 residents (R61) observed during medication pass; failed to properly date eye drop medication when opened for 1 of 2 eye drops for R22 reviewed during medication storage task; and failed to discard an expired eye drop medication for 1 of 2 eye drops for R22 reviewed during medication storage task. Findings include: ACCURATE MEDICATION LABELS: R61's Ativan medication was observed during medication administration observation on 8/14/14, at 7:53 a.m., R61 ' s medication labels for Ativan had read 0.5 mg (milligrams) BID (twice daily) as needed and cetirizine had read 10 mg at bedtime and the labels had no indication of order change. However R61 ' s physician orders dated 6/18/14, read Ativan 1 mg, 0.5 mg to 1 mg three times daily, take one tablet by mouth at bedtime and	F 431	All medications will be accurately labeled, all eye drops will be properly dated when opened and all expired eye drops are discarded. Medication Procedure regarding labeling and Eye Drop Protocol were reviewed at a nursing department meeting on 09/17/2014. Audits will be conducted once per week for a month and once per month for 3 months to monitor for compliance. DON, SD and/or designee are responsible to monitor for compliance. Results are forwarded to QA/QI Committee for review and further recommendation.	

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F 431	Continued From page 84 one half tablet two times a day in the morning and afternoon and cetirizine 10 mg once a morning. Licensed practical nurse (LPN)-E verified at the time of medication administration observation the labels for Ativan and cetirizine did not read what the physician orders had been and the medication labels had no indication on the labels of change in order. During interview on 8/14/14, at 3:49 p.m., director of nursing had stated in regards to medication labels not correct, it is the facility policy to fax the pharmacy new orders and the pharmacy sends new med or new label, there are stickers to put on the labels to identify order change to alert to double check order until the new medication or label comes from pharmacy. Document review of the facility Adams Health Care Center Medication Procedure dated revised 5/10/10, read, "19. Medications with a changed prescription need to be relabeled by a licensed pharmacist." DATE EYE DROPS WHEN OPENED & DISCARD EXPIRED EYE DROPS: R22's eye drops medication were found during the tour of medication storage on 8/14/14 at 2:33 p.m. R22 ' s latanoprost found in the small refrigerator had the expiration date written in of 8/1/14. The licensed practical nurse (LPN)-B confirmed that R22 was receiving the eye drop and that it should have been destroyed. It was also noted that in the west medication cart that timolol ophthalmic eye drops for R22 was opened but not dated. LPN-B confirmed that the eye drops were being used and that the bottle was not dated when it had been opened.	F 431		

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F 431	Continued From page 85 The face sheet indicated that R22 was admitted on 6/23/14. The physician order sheet signed on 7/22/14 indicated that R22 was to receive timolol ophthalmic drops, 0.5% in both eyes once a day and latanoprost ophthalmic drops 0.005% in both eyes once a day at bedtime. The Medication Administration Record (MAR) for August 2014 indicated that R22 had been receiving the undated timolol eye drops and the expired latanoprost eye drops. During an interview with the administrator on 8/14/14 at 3:46 p.m., the administrator confirmed that if the eye drops were not dated when opened or if eye drops were expired they were not to be used and thrown out. During a telephone interview on 8/20/14 at 10:25 a.m. the facility ' s consultant pharmacist verified that it would be his expectation if the latanoprost had written in expired on 8/1/14 it should have been destroyed and the timoptic should have been dated when opened and should have been destroyed. This would be his expectation. An undated policy titled Eye Drop Protocol read that all eye drop containers need to have the date it was opened on it. Eye drops will be thrown away after 30 days. If there is no date on container, eye drops will be destroyed.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		9/17/14

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F 441	Continued From page 86 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 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 implement procedures to prevent the possible spread of	F 441	All residents of Adams Health Care Center who have an order for blood sugar checks have their own glucometer	

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F 441	Continued From page 87 infection during blood glucose monitoring observations for 1 of 1 residents (R25) who had blood sugars taken; and the infection control program lacked documentation of the analysis to determine infection cross-contamination between residents and staff. This had the potential to affect all 45 residents, staff, and visitors. Findings Include: BLOOD GLUCOSE MONITOR LACKED SANITATION TO PREVENT THE SPREAD OF INFECTION TO OTHER RESIDENTS WHO UTILIZE THE SAME MONITOR: R25 had blood drawn on 8/13/14, at 11:40 a.m., for a blood glucose level. Licensed practical nurse (LPN)-C was observed to check R25 ' s blood sugar during which LPN-C had laid the glucometer with used blood glucose strip sticking out of the glucometer (which had visible blood on end of strip sticking out of the glucometer) on R25 ' s tray table. LPN-C had picked up the glucometer from R25 ' s tray table and carried the glucometer out into the hallway to the medication cart with gloved hand, then had removed used blood glucose strip from the glucometer with gloved hand and had set the glucometer on the medication cart and removed gloves from hands inside out with used glucose strip tucked inside of glove and disposed of gloves inside sharps container. LPN-C had then picked up the glucometer from the top of the medication cart with no gloves on and placed the glucometer inside of a drawer of the medication cart. LPN-C had washed hands and after administration of R25 ' s insulin had removed the glucometer from the medication cart, set the glucometer back on top of the medication cart to sign off in computer	F 441	machines and such glucometer machines will be cleaned after each use. An infection surveillance analysis and trending will be completed for staff to determine cross-contamination between residents and staff. The Glucometer Cleaning Policy and the Calling-in Policy were reviewed at a Nursing Department meeting held on 09/17/2014. Audits will be conducted once per week for a month and once per month for 3 months to monitor for compliance. DON, SD/IC and/or their designee are responsible to monitor for compliance. Results will be forwarded to QA/QI Committee for review and for further recommendation.	

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F 441	Continued From page 88 for R25 ' s insulin administration and then had picked up the glucometer and walked down the hallway to the medication storage room and had placed the glucometer in a plastic container. LPN-C had not laid barrier between surface of tray table and glucometer and had not sanitized the tray table after removal of glucometer. LPN-C had had not sanitized the glucometer after use and had placed the glucometer on top of the med cart, inside a drawer of the med cart, inside a plastic container and had not worn gloves when handling the un-sanitized glucometer. LPN-C verified the above at the time. Document review of R25 ' s physician orders dated 7/7/14, identified order check blood sugars before each meal and bedtime. During interview on 8/13/14, at 3:04 p.m., director of nursing stated should have had barrier between glucometer and tray table or should of cleaned tray table and the glucometer should have been cleaned before placing on med cart and putting back into plastic container. Document review of Adams Health Care Center GLUCOMETER CLEANING POLICY undated, read "POLICY: To ensure proper cleaning of glucometer machine between each use for good infection control. PROCEDURE: 1. Wipe the glucometer with a purple top wipe container to disinfect the machine. 2. Glucometer must air dry for 2 minutes after being wiped clean. 3. Do not submerse in water OR leave wrapped in sanitizing wipe. This will wreck the machine. 4. Place glucometer in the designated slot in tote after cleaning. 5. This process must be done after each use. " INFECTION PROGRAM LACKED	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 89 DOCUMENTATION OF THE ANALYSIS TO DETERMINE INFECTION CROSS CONTAMINATION BETWEEN THE RESIDENTS AND STAFF: The facility was unable to provide documentation they had tracked and trended employee illness and infections to determine cross contamination between the residents and staff. During an interview on 8/14/14 at 6:07 p.m., licensed practical nurse (LPN)-A verified there was no documentation to show analysis of the employee illness and infections to determine infection cross contamination between the residents and staff has occurred for staff illness and absence. She stated she completed the analysis when she tracked and trended employee illness, but stated she did not document the analysis as she had the information in her head. The policy entitled Infection Control Employee Health dated 2008 was reviewed and did not address tracking, trending and analysis of employee illness and infections to determine infection cross contamination between the residents and staff.	F 441		

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	245509	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/13/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Adams Health Care Center 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 St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 09/11/2014

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Adams Health Care Center is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1976 and determined to be of Type II(111) construction. In 1992, an addition was constructed and determined to be of Type II (111) construction.. The facility is fully sprinklered. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 42 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		9/10/14

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K 011	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide 2-hour rated construction at building separation wall in accordance with 2000 - NFPA 101, sections 19.1.1.4.1. The deficient practice could affect all 12 out 42 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 08/13/2014, observation revealed, there are open penetrations in the 2-hour rated wall above the ceiling at the west wing, 2 hour fire separation wall from Care Center to Assisted Living has open penetrations around and ends of conduits NOTE: Check all 2 hour fire separation walls This deficient practice was confirmed by the facility maintenance staff (DE) at the time of discovery.	K 011	The open penetrations in the 2-hour rated wall above the ceiling at the west wing and 2hour fire separation wall from Care Center to Assisted Living were fire caulked around ends of conduits. All 2 hour fire separation walls were checked.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		9/17/14

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K 038	Continued From page 3 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2 and 7.1.6. The deficient practice could affect all 12 out 42 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 08/13/2014, observation revealed, that the required North wing exit, the following items were found: 1. Hard path does not go to the public way 2. Hard path that is there is uneven and has more then 1/2 inch elevation change These deficient practices were confirmed by the facility maintenance staff (DE) at the time of discovery.	K 038	Southland construction company will start the hard path to the public way and replace the uneven hard path cement on 09/17/2014. The hard path will be in cement.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide reliable battery operated	K 046	A new battery operated emergency light was replaced in the generator room on	9/11/14

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K 046	Continued From page 4 emergency lighting as required by 2000 NFPA 101, Section 19..2.9.1, and 7.9.2. The deficient practice could affect all 42 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 08/13/2014, observation revealed that the battery operated emergency lighting in the emergency generator room did not work when tested. This deficient practice was confirmed by the facility maintenance staff (DE) at the time of discovery.	K 046	09/11/2014 by Schmitz Electric.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.5 and 9.7, as well as 1998 NFPA 25, section 2-2.1.1 and 2-4.1.4. This deficient practice could affect all 12 out of 42 residents. Findings include:	K 062	The sprinkler heads in the kitchen dish washing area were replaced with Teflon sprinkler heads and the spare sprinkler head box now contains 2 of each spare sprinkler heads. This was done by Olympic Fire on 08/19/2014.	8/19/14

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K 062	Continued From page 5 On facility tour between 8:30 AM and 11:30 AM on 08/13/2014, observation revealed that the following was found: 1. The kitchen dish washing area - sprinkler heads are corroded . This was also noted on the annual fire sprinkler reports from Olympic dated 6/17/14 and 6/13/13 2. Spare sprinkler head box - does not contain (2) spare sprinkler heads of each type These deficient practices were confirmed by the facility maintenance staff (DE) at the time of discovery.	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70, 110-26. The deficient practice could affect 15 out of 42 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 08/13/2014, observation revealed, that the following circuit breaker panels were block: 1. Laundry - soiled utility room	K 147	All items were removed from front of circuit breaker panels on 08/13/2014 and signs were put up that read: "Please do not place anything in front of the circuit breaker panels." The entire facility was checked for this deficiency.	8/15/14

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K 147	Continued From page 6 2. Generator room 3. North wing housekeeping closet NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the facility maintenance staff (DE) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147		