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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 5W0D

Facility ID: 00695

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245522**

2. STATE VENDOR OR MEDICAID NO. (L2) **443343200**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER MEMORIAL HOME**
(L4) **221 6TH STREET SOUTHWEST**
(L5) **MADELIA, MN** (L6) **56062**

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/19/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(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 :
Kathryn Serie, Unit Supervisor — 02/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 02/09/2018 (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 **11/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245522
January 11, 2018

Ms. Dawn Campbell, Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

Dear Ms. Campbell:

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 December 13, 2017 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 9, 2018

Ms. Dawn Campbell, Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

RE: Project Number S5522028

Dear Ms. Campbell:

On November 21, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 19, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 18, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 3, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 3, 2017, effective December 13, 2017 and therefore remedies outlined in our letter to you dated November 21, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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An equal opportunity employer.

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

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(L4) **221 6TH STREET SOUTHWEST**
(L5) **MADELIA, MN** (L6) **56062**

4. TYPE OF ACTION: **2**

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/03/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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**

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From (a) :
To (b) :

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE: Kathryn Serie, Unit Supervisor — Date: 01/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL: Kamala Fiske-Downing, Enforcement Specialist — Date: 1/11/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
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

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28. TERMINATION DATE: (L28)

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30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 21, 2017

Ms. Dawn Campbell, Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

RE: Project Number S5522028

Dear Ms. Campbell:

On November 3, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<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:

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 December 13, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 13, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 3, 2018 (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 May 3, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING ______ B. WING ______	11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST MADELIA, MN 56062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On October 31st, November 1st, 2nd, 3rd, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 152 SS=D	RIGHTS EXERCISED BY REPRESENTATIVE CFR(s): 483.10(b(3)-(7) (b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident’s rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident’s rights to the extent those rights are delegated to the representative.	F 152		12/13/17

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

Electronically Signed — 11/30/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING ______ B. WING ______	11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

(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 152	Continued From page 1	F 152		

(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident’s behalf. The court-appointed resident representative exercises the resident’s rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

(i) In the case of a resident representative whose decision-making authority is limited by State law

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING ______ B. WING ______	11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

(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 152	Continued From page 2 or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident's wishes and preferences were considered for 1 of 1 resident reviewed (R27) who had a guardian making decisions for her related to access to, and retention of, personal property. Findings include: During observation and interview with R27 on 10/31/17 at 11:01 a.m., R27 stated she was upset about not being allowed to keep personal belongings in her room. R27 showed the surveyor a written log document which identified items that had been removed from her room. The written log was signed by social worker (SW)-A. The resident indicated the document was kept in a notebook on her window sill. R27 stated the limitations to access to her personal belongings had started in April of this year, and that she'd been asked to sign a contract during a care conference with her daughters' present. R27's room was observed to be a private unit with three wind chimes hanging from a ceiling fan with butterflies on them. There were a few personal items observed on the window sill and she had a	F 152	F152 R27 has court appointed co-guardians as of 12/28/2016 who bear "all rights and powers under M.S. §524.5-313." The court order states that there is "no appropriate alternative to guardianship that is less restrictive" and that R27 needs help in eight identified categories including taking "reasonable care of the Respondent's clothing, furniture, vehicles, personal effects; and to give any necessary consent to enable, or to withhold consent for, the necessary medical or other professional care, counsel, treatment, or service". This is not a limited guardianship. The survey team reviewed this document during their visit between Oct. 31st and Nov. 3rd. According to CFR 483.10(b4), as cited in the Summary Statement of Deficiencies, "the facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law." There is	

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recliner and a butterfly shaped scarf holder observed on the wall behind her recliner. The remainder of the walls were bare. Two dressers were observed in place along the sides of a wall, otherwise that half of the room was empty. There was no bed in the room and R27 stated she routinely slept in her recliner. There were no odors detected in the room, and no garbage or clutter. A garbage can was observed to have several food wrappers inside it, and there was a stack of empty soufflé cups from medication passes on the window sill. R27 was observed to appear well-groomed, and was alert and oriented to person, place and time. During the interview, R27 was able to appropriately express her concerns.

During continued observation and interview on 11/1/17, at 6:21 p.m. R27 stated she did not feel her rights were respected at the facility related to respect for her and her belongings, "There is a poster on the wall when you come in that talks about respect, but it doesn't happen." R27 displayed a flat facial affect, and paused frequently when speaking, sighing and looking down at her lap. R27 stated she had been "bullied all my life," and that she felt social worker (SW)-A "assumes things she shouldn't and issues a lot of directives."

During further observation and interview on 11/3/2017, at 9:01 a.m. R27 was seated in her recliner and stated her licensed mental health provider (LMHP) informed her that he would sort through her belongings to ensure she was "following [SW-A's] orders." R27 was noted to be fashioning the paper soufflé cups into flower shapes, explaining they could be colored with pencils and placed on the end of a pipe

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a progress note dated 4/19/17 signed by R27’s consulting psychiatrist which identified “hoarding food items and not allow to clean the room. Her irrational and unreasonable demand and behavior, poor insight and impaired judgment have endanger herself and others”. This note was reviewed by the survey team. There is a social service progress note dated 4/25/17 which describes a conversation on 4/21/17 with R27’s guardian. The note describes that R27 and her family had been made aware of LMH’s concerns about the large amounts of personal items, papers, food, food containers, etc. being stored in her room. The note also indicates that R27 refused assistance from facility staff and her family to clean and she refused to clean and dispose of things herself. The note indicates that R27’s guardians provided consent for LMH to clean the room and that they “trust staff’s opinion” on what “to keep and what to toss”. The note concluded that “her room has created a safety, fire, and infection control hazard”. This note was reviewed by the survey team. We recognize that R27 disagrees with and dislikes the decisions that were made on her behalf by her guardians.

There is one other resident residing at this facility who has a court-appointed guardian, who has a diagnosis of an illness requiring a Level II PAS.

We will continue to actively involve R27, her guardians, and the care team in the development of a care plan that

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F 152	Continued From page 4 cleaner/pencil to look like a daffodil. R27 expressed the desire to have additional craft items in her room at this time and described how she used to make pine cone wreaths at home. She pointed to the plastic drawers on her window sill containing paper and pencils, indicating she would like to have more crafts. An interdisciplinary (IDT) note documented by SW-A dated 4/24/17, indicated staff had sorted through R27's room without the resident present. The record indicated the resident had been hospitalized at the time. According to the note, junk mail, garbage, food, etcetera had been tossed. Personal items had been sorted and organized and personal items determined to be unnecessary at the nursing home, had been removed. The note further indicated all legal, business, bank and/or medical paperwork was going to be stored in the social service's office until her [R27]daughters were in town next to pick it up. Further, the note indicated R27's guardian had been informed the resident would be moving to a new room upon her anticipated return. Documentation in IDT notes indicated: (1) 5/20/17, indicated R27 continues to get preoccupied with certain items that are "missing" and has been paranoid staff stole or threw away several of her items while at the hospital; (2) 6/10/17, R27 stated "wanted her stuff back, that it was taken unfairly"; (3) 6/26/17, R27 angry and tearful when her belongings were searched and stated she never signed off on the agreement for these room searches and was reminded her guardians had signed off on this procedure; (4) 8/31/17, R27 commented she was going to jail; and (5) 9/14/17, R27 reported missing pictures of her grandchildren she had in previous room;	F 152	addresses “wishes and preferences”. We will continue to operate under the court ordered guardianship provisions, deferring to the decisions made by R27’s guardians. We will report any decisions made by the guardians that appear to not be in R27’s well-being to State authorities. We will improve our documentation to demonstrate more clearly the involvement of all parties, including the resident, in these types of discussions and decision-making activities. We will continue to take into consideration that a resident may prefer to live in such a manner that jeopardizes his/her health and safety. We will continue to weigh the risks and benefits of those choices and improve our documentation describing reasons for refusing to comply and documenting The Administrator will continue to be responsible for the overall adherence to honoring Resident Rights and Dignity. The Social Service Director will continue to work in conjunction with the IDT to carry out the day to day tasks related to establishing the care plan approaches and goals related to Resident Rights and Dignity. The QAPI committee will review this situation and monitor the documentation for the next two quarters, making recommendations for improvement as needed. Correction Date: December 13, 2017	

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SW-A to look through her purse, SW-A documented she allowed R27 to keep some candy in her purse in the spirit of keeping the room check as the priority. SW-A documented she was not certain she had ever seen R27's photo frames, in the facility, with no further follow-up indicated as to R27's request for those belongings.

Review of R27's medical record indicated the resident had diagnoses including: unspecified affective mood disorder, delusional disorders, personality disorder and anxiety disorder.

A review of R27's most recent annual Minimum Data Set (MDS) assessment dated 9/22/17, indicated no symptoms of depression and a Brief Interview for Mental Status (BIMS) score of 15/15, indicating intact cognition. The MDS also identified behavioral symptoms had improved since the previous assessment and no Care Area Assessment (CAA) for mood, psychosocial or behavioral concerns had triggered. A psychoactive medication CAA dated 10/7/16, indicated R27 used antidepressant (AD) medications.

Guardianship papers from Watonwan County dated 12/28/16, indicated R27 suffered from severe bipolar disease and paranoia, and required assistance in making decisions with respect to medical, nutritional and hygienic needs. Progress notes and care plan entries indicated the resident had a history of hoarding behaviors and that staff, with the guardian's support, had removed items from the resident's room. However, there was no documentation to indicate the resident's wishes were considered prior to staff removing and/or disposing of items

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from R27's room.

The resident's current care plan indicated a problem area of "History of hoarding behaviors indicated concerns with hoarding food products, old documents, empty cups/containers, magazines, medical supply packages/information, etc." The goal identified included to keep the room clean and organized. Approaches identified included: "(1) LMH (Luther Memorial Home) staff will complete routine cleaning and organizing as usual; and (2) visiting counselor will assist in managing hoarding behaviors." In addition, a problem area of "Wants vs. Needs" included: "R27 has a history of asking staff for various items. Guardians have requested R27 only be given items she needs." Items identified as wanted versus needed included: "requesting special soaps, lotions, craft supplies, cleaning supplies, etc." Approaches identified included: "follow guardian recommendations in determining wants vs. needs, which entails only using [R27's] funds to purchase NEEDS. Wants have to be approved through guardians. Guardians requested that R27 go to the activity room to participate in other craft projects and that R27 could access colored pens and paper in her room. " There was no indication R27's wishes had been considered.

When interviewed on 11/2/17, at 10:20 a.m. SW-A stated R27's hoarding behaviors were very, very bad and her room used to be a "huge mess." SW-A stated R27 had refused [refused SW-A's] help, so she [SW-A] had contacted the resident's guardians to visit. SW-A stated a few minutes after the resident's guardian's had arrived, R27 could be heard screaming at the daughters. When mental health concerns

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F 152	Continued From page 7 continued, R27's psychiatrist recommended inpatient hospitalization for a week. SW-A said the interdisciplinary team had collaborated with R27's psychiatrist and guardians, while R27 was absent, to manage mental health symptoms upon return. SW-A stated she had given R27 a list of items she couldn't have in her room before she'd left for the hospital, and had tried explaining that she couldn't have cheese sticks or other open snacks in her room. SW-A stated the guardians have "all powers," and have the right to limit personal belongings. SW-A stated she'd voided a room contract back in September 2017, because R27 had felt "singled out." SW-A stated R27 had a licensed mental health professional (LMHP) providing counseling and help with managing her belongings and thinning them out as needed. SW-A further stated if R27 wanted to do crafts, she would have to do one at a time and return them when they were finished, as she had a history of working on several projects at one time. R27's psychiatry progress notes contained entries indicating evaluations were performed on 3/22/17, 4/19/17, 5/23/17, 6/28/17, 8/16/17, 9/13/17 and 10/17/17. None of R27's psychiatry notes discussed hoarding behaviors, nor were strategies identified for facility staff to manage these behaviors with consideration of R27's preferences/desires. During interview on 11/1/17, at 4:46 p.m. family member (F)-A stated R27 was a hoarder all her life, even when she was residing at home and that she [F-A] was one of her legal guardians. F-A stated a desire to keep R27's belongings under control. F-A stated she had removed craft items she felt were clutter from R27's room. F-A indicated R27 did not like to come out of her	F 152		

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room and was paranoid.

During interview on 11/2/17, at 1:04 p.m. the management consultant (MC) stated he had oversight of the operations and administrator at the facility, and was familiar with R27 as she had resided in several of his other facilities. The MC stated that as long as belongings did not represent a health or safety threat, residents should be able to have them. The MC further commented that with hoarding behaviors such as R27's, "When you have an issue like that it is a fine line," (allowing personal belongings). The MC stated he had not been involved in any recent discussion regarding R27 and was only aware of the situation "at a high level."

During interview on 11/3/17, at 9:07 a.m. geriatric psychiatrist (GP) stated R27 had a "severe personality disorder," and stated, "I can work with [DON] and [SW-A] on more items that she can have." The GP did not see any concern nor contraindication with allowing R27 to have craft items in her room.

R27's LMHP was unavailable for interview on 11/3/17, when attempted to be contacted via phone. On 11/8/17, at 8:46 a.m. the LMHP was able to to return the call and stated he had seen R27 approximately 27 or so times in the facility over many months. He stated sorting R27's belongings and removing them while she was at the inpatient mental health unit would be "Catastrophic, wouldn't it?" The LMHP further stated he felt sorting R27's belongings while she was not in the room would increase her level of paranoia. He had been placed in charge of doing this for the last several weeks, and had not done so feeling the increase in paranoia due to

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F 152	Continued From page 9 removing her items was worse for R27's mental status vs. allowing her to retain the personal items she was desired. The LMHP stated he frequently worked with clients who had hoarding behaviors. The Minnesota Department of Health Combined Federal and State Bill of Rights, revised 11/28/16 indicates: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility: 1. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must promote and protect the rights of the resident. The facility policy entitled Resident Personal Property, last reviewed 7/1/15, indicated residents may retain and use their personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically or programmatically contraindicated for documented medical safety, or programmatic reasons.	F 152		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 157		12/13/17

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F 157	Continued From page 10 (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident’s physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically	F 157		

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F 157	Continued From page 11 update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of symptoms of daytime lethargy, anorexia, and severe edema for 1 of 1 resident (R29) reviewed who experienced a significant decline in activities of daily living and deteriorating medical condition. Findings include: The cumulative diagnosis list updated 9/27/17, identified diagnoses including: type 2 diabetes mellitus, osteomyelitis of right great toe, cellulitis right distal lower limb, chronic renal insufficiency, heart failure, edema and Alzheimer's disease. The annual Minimum Data Set (MDS) assessment dated 10/14/17, indicated R29 is rarely understood and had difficulty focusing attention. The MDS also indicated R29 experienced a decline in activities of daily living (ADL) and required extensive staff assist of two. The MDS revealed R29 received scheduled pain medication and had diabetic foot ulcers which required application of dressings to feet. The care plan last revised 10/24/17, indicated R29 had severe and moderate cognitive impairment-Report change in physical condition and appetite. The physician orders dated 8/8/17, indicated R29 received Seroquel 200 mg mid-day and 100 mg daily at bedtime for resistive behaviors, aggression and agitation towards staff.	F 157	F157 R29 has been a resident of this facility since May 2013. She was first treated for a callous and small amounts of drainage from the great, right toe since November 21, 2016. Treatments continued per doctor's orders. She was hospitalized in September 2017 for "treatment of great right toe" after the nurse noted increased edema in lower legs. She was readmitted on 9/27/17 with osteomyelitis. She was visited by her primary physician on 10/24/17. Notes from that encounter state, "We are not actively treating her osteomyelitis. It is possible this patient would have septic issues down the road. Currently we are managing her medications at minimal level to make her symptomatically comfortable. Therefore I would not start any active treatment." This was discussed and agreed to by R29's medical power of attorney. Additionally, R29 had been prescribed Seroquel since her day of admission, starting with a 25 mg dose on admission and gradually increasing over the years. The physician order dated 8/8/2017 listed in the Summary of Deficiencies had been reviewed by the consulting pharmacist on 8/16/17, 9/13/17, and 10/5/17 with no problems noted. LMH was following R29's physician's orders during the timeframe of the survey, providing comfort cares. There is no corrective action to	

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Review of nursing notes dated 10/11/7 through 10/26/17, identified that R29 exhibited a decline in appetite and ability to eat, little energy, feeling tired, lethargy and increase in confusion.

During observation in the dining room on 11/2/17, at 8:24 a.m. R29 was seated at the dining table. Nursing assistant (NA)-A placed a bite of corn flakes soaked in milk in R29's mouth. R29 chewed the cornflakes repeatedly, not swallowing. NA-A asked R29 "are you going to wake up to eat?" R29 with eyes closed said "oh my food is here?" R29 was sitting with her eyes half open attempting to focus. R29 picked up her glass and took 2 sips. It was noted her head was hanging. When the surveyor questioned R29 how she was, she responded "not ok, I'll be better tomorrow" R29 proceeded to fall asleep. Interview with NA-A at this time revealed R29 had been feeding herself after set up, until approximately two weeks ago; however, now when staff tried to get her to eat she would only lick at the food on the spoon, or chew and chew.

When interviewed on 11/2/17, at 11:57 a.m. R29's primary physician (MD)-B explained that have not communicated that R29 recently exhibited lethargy symptoms, decrease ability to feed herself and/or decrease in ability to formulate thoughts. MD-B confirmed that further assessment would be conducted.

Documentation review of the pharmacy note dated 11/2/17, indicated: 11/2/17-Seroquel 200 mg at noon and 100 mg bed time (HS). Present nursing notes are reporting significant decline. Constant daytime lethargy, anorexia, severe edema not controlled by Lasix 40 mg morning and 20 mg afternoon. Neurology psychiatry

implement as R29 expired on 11/15/2017.

Currently, there are two residents whose conditions have changed, requiring notification of themselves, their representative, and their physician. These notifications have been documented in the medical record.

The policy and procedure for Reporting Conditions to the Physician will be reviewed and updated. Nursing staff will be re-educated on its provisions. It will also be made available to nursing staff so they can produce it upon request.

The Director of Nursing will remain overall responsible for ensuring that the nursing staff are competent to identify changing clinical conditions that meet the criteria for notification of resident, representative(s), and physicians and are competent to follow through with said notifications and document these findings and actions in the medical record. The Director of Social Services will remain overall responsible for notifying the resident and representative of changes related to transfer, discharge, and roommate changes. An audit of these procedures will be conducted and reported on at the quarterly QAPI committee meeting for the next two quarters. The committee will assess the situation and make recommendations to ensure continued compliance.

Completion Date: December 13, 2017

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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 157	Continued From page 13 problems = Alzheimer's dementia hallucinations: anxiety, insomnia, paranoid. Suggest: Immediate dose reduction of Seroquel to 50 mg a.m. and 50 mg midday and 100 mg HS. Immediate pain assessment addressing painful edematous feet and osteomyelitis pain. Currently only Tylenol 1000 mg bedtime is ordered. When interviewed on 11/3/17, at 10:30 a.m. geriatric psychiatrist (GP) verified being unaware of R29's decline in activities of daily living including the ability to feed herself. Upon providing the observation noted on 11/2/17, where R29 chewed over and over the same mouthful of food, licked at the food and did not recognize she was at the table to eat; GP responded, "No, I knew none of this, nobody told me, she could be going septic". GP further revealed that she was unaware that behavior incidents had decreased in the last three months. GP further stated a reduction in R29's psychoactive medications would be appropriate given her current level of sedation. A policy was requested for notification of change to the physician on 11/3/17, none was provided.	F 157		
F 176 SS=D	RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE CFR(s): 483.10(c)(7) (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician	F 176	F176	12/13/17

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participated as part of the interdisciplinary team to determine whether self-administration of medications was appropriate for 1 of 1 resident (R27) reviewed who self-administered medications and had a history of medication noncompliance.

Findings include:

R27's most recent annual Minimum Data Set (MDS) assessment dated 9/22/17, indicated no symptoms of depression and the Brief Interview for Mental Status (BIMS) score identified 15/15, intact cognition. The MDS further identified R27's behavioral symptoms had improved since the previous assessment. A Care Area Assessment (CAA) did not trigger for mood, psychosocial nor behavioral concerns.

R27's psychoactive medication CAA dated 10/7/16, indicated R27 used antidepressant (AD) medications.

The MDS face sheet dated 11/3/17, indicated diagnoses of unspecified affective mood disorder, delusional disorders, personality disorder and anxiety disorder.

The guardianship papers from Watonwan County, dated 12/28/16, indicated R27 had been diagnosed with severe bipolar disease and paranoia; and also needed assistance in making decisions with respect to medical, nutritional and hygienic needs.

R27's care plan did not identify whether R27 did or did not have the capability to self-administer medications.

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A signed physician order dated 12/13/2016 stating that R27 is able to self-administer medications is part of R27’s medical record in the “paper chart”. The annual review of this order was completed and signed by R27’s provider on 11/2/2017. The physician orders were updated. The care plan will be updated to reflect this information.

Currently, there are sixteen residents who have been assessed as capable of self-administration of medication. They retain the choice as to whether they want to exercise that right.

The Self-Administration of Medications policy and procedure will be reviewed and updated. The admitting nurse will continue to make recommendations to the primary physicians of newly admitted residents as to whether or not the person has been assessed as capable or incapable of self-administration of medications. The IDT will continue to review residents’ capabilities at least annually and after any significant changes in cognition, abilities, etc.

The Director of Nursing will remain responsible for ensuring that the system includes physician participation in the decision-making process. She may delegate her authority to carry out the procedure to other licensed nurses. This policy/procedure will be reviewed by the QAPI committee at its next meeting and audited for compliance for the next two quarters.

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F 176	Continued From page 15 A Limited Evaluation progress note, dated 6/1/17 by R27's family nurse practitioner (FNP) indicated R27 was hospitalized in 4/17 for refusing medications, and had a history of dementia and paranoia. R27's Physician Orders, dated 11/3/17 included amlodipine besylate (a cardiovascular agent), hydralazine (an antihypertensive), and warfarin sodium (a blood-thinner). R27's Medication Administration Sheets, dated 11/3/17 indicated R27 could self-administer her medications after set-up. The start date of the order to self-administer was dated 11/2/17. During observation and interview on 11/1/17, at 6:21 p.m. R27 was noted to have a brown-colored pill which she stated was warfarin and the white pill located in the medication cup, was for blood pressure. The medication cup was located on the overbed table in R27's room. R27 explained the nurse left the medications with her and that she would take them later. During interview on 11/3/17, at 9:01 a.m. R27 was seated in her recliner, making flowers out of empty medication cups she had stored on the window sill. R27 stated staff were now observing her while she finished taking her medications. She indicated this was a new/recent occurrence within the last couple of days. When interviewed on 11/3/17, at 9:07 a.m. R27's geriatric psychiatrist (GP) stated she did not think R27 should be left alone without supervision with prescribed medications due to R27's hoarding behaviors and medication noncompliance history; stating, "I am glad you brought that up."	F 176	Completion Date: December 13, 2017	

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F 176	Continued From page 16 During interview on 11/3/17, at 10:29 a.m. RN-D stated she had not noticed that R27 would hoard medications and felt R27 would be capable to take pills on her own in her room. RN-D confirmed R27's physician had not been consulted as part of the interdisciplinary assessment; however, a fax had just been sent this week to obtain an order. RN-D reported that R27 was "very intelligent," and did sometimes refuse medications. During interview on 11/3/17, at 12:42 a.m. the director of nursing (DON) stated the facility lacked policies and procedures related to self-administration of medication, and it was something they were "working on."	F 176		
F 241 SS=D	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R27) reviewed for dignified services was treated with respect and dignity related to management of her hoarding behaviors, and retention of her personal property items. Findings include: During observation and interview with R27 on	F 241	F241 R27 expressed dissatisfaction with the situation of room cleaning during an interview with the survey team on 11/1/2017 that had occurred in April 2017 and subsequently per a room management plan. The plan had been discontinued on 9/28/2017. We acknowledge that R27 continues to feel	12/13/17

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10/31/17 at 11:01 a.m., R27 stated she was upset about not being allowed to keep personal belongings in her room. R27 stated limitations to access to her personal belongings had started in April of this year, and that she'd been asked to sign a contract during a care conference with her daughters' present to allow her room to be searched and items removed to prevent clutter. During the interview, R27 was able to appropriately express her concerns.

R27's room was observed during the 11:01 a.m. 10/31/17 observation, to be a private unit with three wind chimes hanging from a ceiling fan with butterflies on them. There were a few personal items observed on the window sill and she had a recliner and a butterfly shaped scarf holder observed on the wall behind her recliner. The remainder of the walls were bare. Two dressers were observed in place along the sides of a wall, otherwise that half of the room was empty. There was no bed in the room and R27 stated she routinely slept in her recliner.

During continued observation and interview on 11/1/17, at 6:21 p.m. R27 stated she did not feel her rights and feelings were respected at the facility related to respect for her and her belongings, "There is a poster on the wall when you come in that talks about respect, but it doesn't happen." R27 displayed a flat facial affect, and paused frequently when speaking, sighing and looking down at her lap. R27 stated she felt "bullied" by social worker (SW)-A and that SW-A "assumes things she shouldn't and issues a lot of directives."

When interviewed on 11/2/17, at 10:20 a.m. SW-A stated due to her clinical social work

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upset about these past events. We believe that the contents of the social service progress note dated 9/28/2017 describes the current situation for R27 and was not thoroughly considered by the survey team before drawing the conclusion that R27 was not being treated with dignity and respect relating to the management of her personal property, despite her ongoing tendency to display hoarding behaviors.

There are no other residents identified that are affected by this alleged deficient practice.

The policy titled “Resident Personal Property” will be reviewed and updated if necessary.

The Director of Social Services will continue to work in conjunction with the IDT to ensure that each resident is provided a dignified existence which promotes a quality of life that recognizes individuality. The QAPI committee will review this situation at its next meeting and make recommendations for continued improvement as needed.

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F 241	Continued From page 18	F 241		

license, she had originally been providing care for R27 when she first came. SW-A further stated the resident's hoarding behaviors were very, very bad and her room used to be a "huge mess." SW-A acknowledged R27 felt "singled out," by the room contract and was upset about her room being searched.

Social Service progress notes included feedback from April 2017 when SW-A had spoken with R27's daughters
regarding what to do with the resident's room situation. SW-A had documented that [R27's] hoarding behaviors had increased over the past few months, and her room was cluttered with a large amount of papers and personal items, including food and food containers she refused to throw away. SW-A had documented 4/19/17, "Upon [R27's] anticipated return to [facility name] she will need to sign off on a room agreement that will specifically state what she is allowed or not allowed to keep in her room." Additional documentation from 4/24/17 verified staff had sorted through the resident's belongings while the resident was hospitalized. The note indicated junk mail, garbage, food, etc had been thrown away, and R27's personal items were sorted, organized or sent home with the resident's daughters. In addition, arrangements were made for R27 to move to a new room upon her hospital return.

Additional social service progress included:
5/20/17: [R27] "has been back at [facility] for a little over a week. She has been following her room and medication agreements for the most part....Her mood has been up and down and she continues to get preoccupied with certain items that are 'missing'." 6/26/17: [R27] "was angry and tearful when her belongings were searched

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F 241	Continued From page 19 and stated she never signed off on the agreement to these room searches, was reminded her guardians had signed off on this procedure." 7/6/17: "Room check completed 7/6/17, ...Several straws, cookies, rice Krispies, jellies, applesauce and one empty cup were removed. [R27] was upset, stating she needed the items in her bag in case she got sent 'somewhere'. " R27's licensed mental health provider (LMHP) was unavailable for interview on 11/3/17, when attempts were made to contact him by phone. On 11/8/17, at 8:46 a.m., the LMHP was able to return the call and stated he had seen R27 approximately 27 or so times in the facility over many months. The LMHP stated he felt sorting R27's belongings while she was not in the room could increase her level of paranoia. The Minnesota State Combined Federal and State Bill of Rights, revised 11/28/16 includes: The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility: 1. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must promote and protect the rights of the resident.	F 241		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered	F 280		12/13/17

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F 280	Continued From page 20 plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident’s strengths and needs. (iii) Incorporate the resident’s personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans	F 280		

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F 280	Continued From page 21 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise and individualize the care plan for 1 of 1 resident	F 280	F280 It□s been proposed to schedule a care	

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(R19), who experienced behavioral symptoms and was on an antipsychotic medication (Seroquel) for behaviors.

Findings include:

Review of R19's physician orders dated 10/3/17, the primary care provider ordered to titrate (reduce) the dose from Seroquel 50 mg to 25 mg and discontinue after 4 days.

Review of R19's nurse's notes from 10/5/17 through 11/2/17 indicated R19 would yell out for help almost every night. R19 was noted to have trouble falling asleep or staying asleep throughout the night.

The nurses notes dated 10/23/17, at 7:19 a.m. documented that R19 yelled out, was taken to the bathroom but was continued yelling out. R19 had taken off all her clothing and was found lying naked in bed. R19 was transferred to a wheelchair and brought from her room to the nurse's station where she reportedly called staff names and was "messing with everything she could get her hands on."

Review of R19's current undated electronic care plan indicated there were no interventions specific to behaviors listed on the care plan. Nursing staff were only to identify triggers and underlying causes of behavior, but there were no specific behaviors noted. Nursing staff were to assess and treat pain, identify patterns of behavior, and rule out delirium, and administer medications as ordered. There was no mention of any behavioral interventions for R19. Nursing assistants were to maintain the safety of the resident, report pain to the nurse, offer

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conference with R19 to discuss the mood and behaviors of inability to fall asleep and stay asleep, calling out for help, and general anxiousness, complaints of stomach pain, agitated movements, etc. Requested participants will be the IDT, family, and physician. As it is, the Seroquel was discontinued on 11/14/17 with no documented positive effects demonstrating an improved ability to sleep at night and reduced feelings of anxiousness. It□s been suggested that R19 is sleep-deprived and may require a modification in how visitors and family approach her when she is sleeping during daytime hours. R19 will be 100-years old in December 2017 and may require more sleep than her family is willing to accept.

All residents are offered an opportunity to participate in the development and maintenance of their care plan. A review of the other residents who receive anti-psychotic medications will be completed, noting whether a valid indication for the medication is present and whether non-pharmacological interventions are part of the care plan.

We will review and update as needed the policy titled Care Plan and re-educate the IDT as needed.

The DON and IDT will be responsible for including the residents and their designated parties in the development and maintenance of care plans. Review of R19□s case will be discussed at the next QAPI committee meeting.

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F 280	Continued From page 23 conversation, present tasks one at a time, and redirect a restless resident. There was no mention on what types of behaviors the resident had or what types of behaviors needed to be reported to the nurse. Review of the Minimum Data Set dated 9/23/17, indicated R19 had no physical, verbal or other behaviors of any kind and had no changes in behavior at the time of those assessments. Observations on 10/31/17 at 12:30 p.m. of R19 indicated she was sitting in her wheelchair in her room, quietly watching her TV. Observation again at 3:30 p.m. revealed R19 was in the hallway outside her room, dressed up for Halloween, smiling and waiting to pass out candy to trick-or-treaters. Observation on 11/2/17 at 6:39 a.m. indicated R19 was sitting in her wheelchair in her room, asleep. At 6:50 a.m., R19 was awake and now sitting in her wheelchair in the doorway of her room. No behaviors were noted. Later that day at 1:33 p.m., R19 was observed being wheeled to bingo by staff and interacting well and smiling. Interview on 11/02/17 at 1:34 p.m. with licensed practical nurse (LPN)-B indicated she felt R19 had not fared well behaviorally without the use of Seroquel once it had been discontinued on 10/3/17. R19 was up at night, trying to transfer herself, sitting in hallways, and was known to be anxious. She was restarted on the Seroquel after the 10/23/17 episode as noted above. Interview and document review on 11/02/17 at 1:45 pm with pharmacist-B indicated he agreed according to the nursing documentation, there	F 280	Completion Date: December 13, 2017	

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F 280	Continued From page 24 was no supporting evidence to show non-pharmacological interventions had been tried first prior to initiating R19's antipsychotic Seroquel. Furthermore, the root cause of R19's behaviors had not been assessed. He indicated he made a note just previous to our interview and recommended to check her thyroid laboratory values to see if they were within normal limits. He also stated R19 had a complex orthopedic history involving spinal problems that he felt may explain her calling out for help. Document review of the revised February 2017 Care Planning and Care Conference policy indicated Luther Memorial Home will work with each individual resident and their families/designee to develop a plan of care that all are in agreement with. The care plan will be reviewed quarterly with the interdisciplinary team, the resident or resident's representative and staff. Corrections will be made to the plan of care as needed. Care plans are an on going process and will have updates made on as-needed basis with any changes. The care plan will be reviewed and updated as appropriate for a new admission, a resident who returns from a hospital, or has a significant change of condition.	F 280		
F 285 SS=D	PASRR REQUIREMENTS FOR MI & MR CFR(s): 483.20(e)(k)(1)-(4) (e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 285		12/13/17

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F 285	Continued From page 25 (1) Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. (2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. (k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-	F 285		

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(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and

(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-

(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,

(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and

(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

(3) Definition. For purposes of this section-

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F 285	Continued From page 27 (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. (k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a Level II Pre-admission Screening and Resident Review (PASARR) was completed for 1 of 1 resident (R27) reviewed for PASRR with a history of serious mental illness (MI). Findings include: R27's most recent annual Minimum Data Set (MD) assessment dated 9/22/17, indicated no symptoms of depression, and a Brief Interview for Mental Status score (BIMS) of 15/15, indicating intact cognition. The MDS further identified R27's behavioral symptoms had improved since the previous assessment. A Care Area Assessment (CAA) did not trigger for mood, psychosocial, or behavioral concerns. R27's psychoactive medication CAA dated	F 285	F285 A request for a Level II PAS was submitted to county human services on 11/7/2017. The local mental health authority designee□s response was received dated 11/16/2017, stating that I do not believe an additional assessment is needed due to the following: R27 is diagnosed with Dementia. She is receiving regular psychiatric and therapy visits at the Nursing Home. She has overriding physical needs requiring Nursing Home Level of Care. She is also receiving Care Coordination through Blue Plus. This information was mailed to this facility, R27□s guardians, and R27□s Blue Plus care coordinator. We will refer all residents with newly	

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10/7/16 indicated R27 received antidepressant (AD) medications.

The MDS face sheet for R27 dated 11/3/17, indicated diagnoses of unspecified affective mood disorder, delusional disorders, personality disorder and anxiety disorder.

The guardianship papers from Watonwan County, dated 12/28/16, indicated R27 had been diagnosed with severe bipolar disease and paranoia, and needed assistance in making decisions with respect to medical, nutritional and hygienic needs, as she had failed to properly manage her activities of living and medication needs in the community. Guardianship was appointed to two family members as R27 was unable to manage her care appropriately.

R27's PASARR completed by the Senior Linkage Line dated 9/22/16, stated: consumer meets requirements for nursing facility level of care under Medicaid. The screening did not identify a major mental disorder nor did the screening identify that mental illness had significantly impacted R27's ability to care for herself in the community.

R27's care plan, dated 11/3/17, indicated problems related to history of MI, which indicated a goal of following recommendations from the counselor and psychiatrist; approaches included encouraging the resident to make decisions; encouraging activities, especially those involving mental exercise and promoting resident's sense of control over situation.

During observation and interview on 10/31/17, at 11:01 a.m. R27 stated she was upset as she was

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evident, related conditions for a Level II screen. We recognize that a resident may be admitted to this facility with indications for a Level I screen and then experience a condition change that might require a Level II screen.

We will review and update the policy describing Pre-admission Screens (PAS). The Administrator and Social Services Director will be responsible to ensuring compliance with this activity. The Medical Records Consultant will be asked to complete an audit of admission records to verify the presence of a PAS, noting if a Level I or II was required. Results will be reported at the next QAPI committee meeting.

Completion Date: December 13, 2017

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not allowed to keep personal belongings in her room. R27 presented the surveyor with a document which included a written log signed by social worker (SW)-A identifying items removed from R27's room. This was kept in a notebook located on the window sill.

During continued observation and interview on 11/1/17, at 6:21 p.m. R27 stated she did not feel her rights were respected, including respect for her and her personal belongings. R27 stated, "There is a poster on the wall when you come in that talks about respect, but it doesn't happen." R27 displayed a flat facial affect, and paused frequently when speaking, sighing and looking down at her lap.

During interview on 11/1/17, at 4:46 p.m. family member (F)-A stated R27 was a hoarder all her life, even when living at home. F-A indicated she was one of the legal guardians appointed by the court due to R27's inability to care for herself. F-A stated R27 had significant mental health issues for many years prior to admission and was paranoid and did not like to come out of her room.

During interview on 11/2/17, at 10:20 a.m. SW-A stated she had originally been providing R27 when she first came, because she had her clinical social work license. SW-A explained that R27 exhibited hoarding behaviors which were very, very bad and her room used to be a "huge mess". SW-A stated that R27 had a recent inpatient stay at a psychiatric facility related to mental health concerns. SW-A confirmed she was surprised when reviewing R27's initial PASRR which did not identify a MI diagnosis, given her history. She indicated that mental

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F 285	Continued From page 30 illness was the "primary reason for admission". SW-A stated she had never pursued obtaining a Level II screening after R27 was admitted in September 2016, nor upon return from the most recent psychiatric stay in April 2017, even though being aware that R27 had significant mental health diagnoses. When interviewed on 11/3/17, at 9:07 a.m. R27's geriatric psychiatrist (GP) stated, "This is a very hard case, we have tried to help her with some medications related to her mood, and she refuses." The GP stated R27 had a "severe personality disorder." During interview on 11/3/17, at 10:00 a.m. a Senior Linkage Line representative (SLL)-A stated the PASARR information was only as good as the information provided by the hospital and/or transferring facility. SLL-A stated it would normally be up to facility staff to contact the county about a Level II PASRR when they noted a discrepancy in the admitting paperwork. The facility policy, entitled Pre-Admission, last reviewed 5/99, indicated the Pre-Admission Screening (PAS) information is discussed with the prospective resident and/or family. The Social Worker will assist in arranging the PAS with the county.	F 285		
F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323		12/13/17

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F 323	Continued From page 31 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed’s dimensions are appropriate for the resident’s size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure mechanical lifts were properly equipped with a safety tab for 1 of 2 residents (R21) observed who were transferred using a mechanical lift for mobility and failed to ensure bedrails had been assessed for safety for 5 of 5 residents (R25, R29, R35, R39, R50) reviewed for accidents. Findings include: Observation and interview on 11/1/17 at 7:15 p.m. of nursing assistant (NA)-D attempting to transfer R-21 from her wheelchair to her bed revealed NA-D proceeded to place the strap around R21's back, and placed the loops from that strap into	F 323	F323 R50 expired on 11/11/17. R29 expired on 11/15/17. The quarter-rails for R35 and R39 have been replaced with the FDA recommended size. At this writing R25 does not have a side rail on the bed. The safety tabs were replaced on the EZ Machines by the Maintenance Supervisor (MS). Additional tabs were ordered and will be stored in a place that the nurses have access. A routine safety inspection will be completed by the Maintenance Director or his designee on a monthly basis which will include ensuring that the safety tabs are in place and functional.	

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F 323	Continued From page 32 the mechanical lift on each side. The left side of the mechanical lift had a rubber safety tab that was positioned away from the mechanical lift loop. The right side of the lift had no safety tab at all. NA-D then attempted to lift R21 up from her wheelchair before being stopped by this surveyor for safety. NA-D was unsure what the rubber tab was located on the left side, it's purpose nor reason it was facing away from the loop of the mechanical lift. NA-D was unaware where staff stored additional tabs. NA-D left the room and questioned licensed practical nurse (LPN)-C the location where the safety tabs were stored. LPN-C responded that only maintenance had them and instructed NA-D to find a mechanical lift which had both safety tabs attached before attempting to transfer R21 and/or another resident. Further interview on 11/1/17, at 7:20 p.m. with LPN-C indicated she was unaware staff had been using the mechanical lifts without the necessary safety tabs; a resident safety concern. Observation 11/1/17, at 8:00 p.m. of the mechanical lift located on the east nurses station hallway had no safety tabs noted on the lift. Interview on 11/1/17, at 8:02 p.m. with NA-F indicated she used that mechanical stand lift to transfer one [unidentified] resident tonight without the safety tabs attached. NA-F was unaware whether extra safety tabs were available and unaware the lift should not be used without the appropriate safety attachments. Observation on 11/1/17, at 8:05 p.m. in the middle hallway revealed there was another mechanical lift with one safety tab missing.	F 323	The RN Unit Coordinator is working with the MS to verify that any other residents who have been assessed and approved for side rail use have the FDA recommended size rails installed. The RN Unit Coordinator and MS will be responsible for ensuring that this activity is completed and sustained. Safety audits will continue and results reported to the safety committee on a quarterly basis. Completion Date: December 13, 2017	

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Interview on 11/2/17, at 10:20 am with the management consultant indicated his expectation was staff were to not use the lifts without the appropriate safety tabs in place.

Interview on 11/2/17, at 10:45 a.m. with the maintenance supervisor (MS) indicated he put new tabs on today when he became aware they were off and ordered additional tabs as had not been informed they were missing. MS confirmed he keeps the tabs in his office, which is locked and staff do not have access, especially after hours.

Interview on 11/3/17, at 10:02 a.m. with the director of nursing (DON) indicated her expectation was staff were to ensure safety tabs were on mechanical lifts prior to use for patient safety.

Review of the undated EZ Way Smart Stand Operator's Instructions, EZ Way Smart Stand® Safety & Maintenance Checklist, indicated the following components and operating points be scheduled for inspection at intervals not greater than one month. Any detected deficiency must be rectified before the stand is put back into service. Safety tabs need to be checked to make sure they are in place.

During observations on 10/31/17, at 1:19 p.m. and again at 3:10 p.m. R50 had both top half bedrails in the up position while he was resting in bed. On 11/1/17, at 11:14 a.m. an interview was attempted with R50 while he laid in bed; however, due to his terminal illness of cancer, he could not answer and was unable to make his needs known, but was observed to move on his

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own from side to side within the bed.

Document review indicated R50 was admitted on 8/8/17, with an active diagnosis of lung cancer which had metastasis to brain and other organs. The admission Minimum Data Set dated 8/15/17, and the significant change MDS (hospice) dated 9/27/17, both indicated he was rarely understood when interviewed.

Review of the bed rail assessment for R50 indicated, "Alert and oriented x 3 during day," and not "Confused at night."; and "Resident wants side rails." The team recommended bedrails be placed for R50 at all times while he was in bed. "Resident requests side rails."

Review of R50's medications revealed he had physician ordered Lorazepam 2 milligrams/milliliter (mg/ml) ordered for an emergency incident of seizure.

Facility walk through with the maintenance supervisor on 11/2/17 indicated the bed rails for the observed residents R25, R29, R25, R39, and R50, measured 6 and 1/8 inches from the bottom of the bed rail to the top of the bed frame. That measurement was larger than the recommended 4 and 3/4 inches recommended maximum guidance set by the Food and Drug Administration (FDA) for Bed Rail Safety.

Interview on 11/2/17, at 11:45 with the management consultant (MC) indicated he was unaware the bedrails were outside the recommended size requirements recommended by the FDA. MC indicated the previous maintenance supervisor had been provided with the bed rail safety guide and he was informed the

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rails met the guidance. MC agreed the 6 and 1/8 inch would pose an entrapment hazard.

Interview on 11/3/17, at 10:10 a.m. with the DON indicated she agreed R50's bedrails assessment was not accurate as the resident could not possibly agree to "Want side rails" when unable to speak or make his needs known. The DON further agreed none of the side rails in the facility had not been assessed for device safety.

The quarterly Minimum Data Set (MDS) assessment dated 8/22/17, identified R39 had severe cognitive impairment, diagnoses of dementia and anxiety and required extensive physical assistance from staff for activities of daily living (ADLs) including transfer and bed mobility. During an observation on 11/1/17, at 7:03 p.m. R39 was resting on the bed with the quarter bedrail in the raised position on the open side of the bed with the other side of bed placed up against the wall. Gaps were noted in Zones 2 and 4 of the bedrail.

The MDS dated 10/14/17, identified R29 had severe cognitive impairment, diagnoses to include Alzheimer's disease and required physical assistance from facility staff for activities of daily living (ADLs) including transfer and bed mobility. During an observation on 10/31/17, at 1:47 p.m. R29 was resting on the bed with bilateral quarter bedrail's in the raised position.

R25's admission MDS dated 10/2/17, identified a Brief Interview for Mental Status score of 9/15, indicating moderate cognitive impairment. R25 required supervision and setup with bed mobility and was extensive assistance of one staff

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F 323	Continued From page 36 member for transfers. During observation and interview on 10/31/17, at 1:04 p.m. R25 was noted to have a raised quarter bedrail on the left side of her bed which was elevated. The bedrail had large gaps in Zone 2 and Zone 4, and was wobbly when grasped and lightly shaken. R25 denied using the rail for bed mobility and stated, "Why would I use that anyway to get in and out of bed, it is shaky?" The quarterly MDS dated 8/28/17, identified R35 had moderate cognitive impairment, diagnoses to include Alzheimer's disease and required physical assistance from facility staff for activities of daily living (ADLs) including transfer and bed mobility. R35's bedrail assessment, dated 3/21/17 indicated she was safe to have a bedrail up on the right side of the bed; however, did not contain an assessment of the safety of the bedrail within recommended dimensional limits. During an observation on 10/31/17, at 10:28 a.m. R35 was resting on the bed with the quarter bedrail in the raised position on the open side of the bed with the other side of bed placed up against the wall. Gaps were noted in Zones 2 and 4 of the bedrail. During interview on 11/3/17, at 12:42 p.m. the DON stated they had assessed rails in the past to determine whether or not they used as a restraint device, but it was a "Good point," to assess them for safety including proper dimensional limits. She verified the current bedrail assessments had not included determining whether they were within recommended dimensional limits, and thought maintenance had addressed this.	F 323		

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F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in	F 329		12/13/17

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F 329	Continued From page 38 an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate the need to reduce an antipsychotic medication dose and failed to implement non-pharmacological interventions and assess for alternative causes of behavior prior to administration of an antipsychotic medications (Seroquel) for 2 of 5 residents (R29, R19) reviewed for unnecessary medications. Findings include: The cumulative diagnosis list for R29, updated 9/27/17, identified diagnoses including: type 2 diabetes mellitus, osteomyelitis of right great toe, cellulitis right distal lower limb, chronic renal insufficiency, heart failure, edema and Alzheimer's disease. The annual Minimum Data Set (MDS) assessment dated 10/14/17, indicated R29 is rarely understood and had difficulty focusing attention. The MDS also indicated R29 experienced a decline in activities of daily living (ADL) and required extensive staff assist of two. The MDS revealed R29 received scheduled pain medication and had diabetic foot ulcers which required application of dressings to feet. The care plan last revised 10/24/17, indicated R29 had severe to moderate cognitive impairment-Psychotropic medications, nurses-monitor for adverse effects, irritability, psychomotor slowing. Report change in physical condition and appetite.	F 329	F329 R29 expired on 11/15/17 and is no longer affected by this practice. The IDT followed through with the pharmacy consultant□s recommendations and confirmed that R19□s lab values do not indicate a cause for her calling out for help. A recommendation for a sleep study is being proposed to the family and physician to determine if R19 is sleep-deprived. R19 will be 100 years old next month. It□s been observed that visitors and family often wake the resident, disrupting her ability to obtain rest at key times of the day which may result in her having trouble falling asleep and staying asleep at night. The Seroquel was discontinued on 11/14/17 without positive effects or improvements in R19□s ability to sleep or any noticeable decrease in feelings of anxiousness and restlessness between 10 PM and 7 AM. A review of the other residents who receive anti-psychotic medications will be completed, noting whether a valid indication for the medication is present and whether non-pharmacological interventions are part of the care plan. The facility□'s procedure for behavior monitoring, medication review, intervention effectiveness, etc. will be reviewed at the next QAPI committee meeting.	

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F 329	Continued From page 39 The physician orders dated 8/8/17, indicated R29 received Seroquel 200 milligrams (mg) mid-day and 100 mg daily at bedtime (HS) for resistive behaviors, aggression and agitation towards staff. Review of nursing notes dated 10/11/17 through 10/26/17, identified that R29 exhibited a decline in appetite and ability to eat, had little energy, experienced feeling tired, and had an increase in confusion. Review of physician visit notes dated 10/24/17, indicated R29 had a chronic wound on right great toe medial aspect which had been diagnosed as osteomyelitis. The note indicated R29's family had chosen not to treat, recognizing the risks, and that bilateral leg swelling had worsened. In addition, the physician noted R29 was significantly confused due to dementia. The prescribed plan included: It is possible to increase her diuretics but that would cause profound hypokalemia which might cause cardiac issues. For that reason I did not make changes in medications. Suggested leaving her legs elevated as much as possible. We are not actively treating her osteomyelitis. It is possible this pt. (patient) [R20] would have septic issues down the road. Currently we are managing medications at minimal level to make her symptomatically comfortable. Therefore I would not start any active treatment. The physician's progress note documentation was lacking any indication an assessment related to the current dose of Seroquel had been addressed and/or reviewed. When interviewed on 11/2/17, at 7:27 a.m. nursing assistant (NA)-E revealed R29 seemed to be tired more recently and the nursing assistants had been transferring R29 from one surface to	F 329	The IDT will continue to collaborate with the pharmacy consultant, reviewing his recommendations monthly and involving the residents physicians with any medication order changes. The DON will continue to be responsible for this system and ensure compliance. Completion Date: December 13, 2017	

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F 329	Continued From page 40 another with a standing lift. NA-E confirmed that during cares R29 would try to grab and to hit out; however, the incidents are fewer. During observation in the dining room on 11/2/17, at 8:24 a.m. R29 was seated at the dining table. Nursing assistant (NA)-A placed a bite of corn flakes soaked in milk in R29's mouth. R29 chewed the cornflakes repeatedly, not swallowing. NA-A asked R29 "are you going to wake up to eat?" R29 with eyes closed said "oh my food is here?" R29 was sitting with her eyes half open attempting to focus. R29 picked up her glass and took 2 sips. It was noted her head was hanging. When the surveyor questioned R29 how she was, she responded "not ok, I'll be better tomorrow." R29 proceeded to fall asleep. Interview with NA-A at this time revealed R29 had been feeding herself after set up, until approximately two weeks ago; however, now when staff tried to get her to eat she would only lick at the food on the spoon, or chew and chew. During a interview with the director of nursing (DON) at on 11/2/17 at 11:09 a.m. she stated that R29 got up and walked to the TV lounge on her own last week. The DON described R29 as having varying levels of alertness. When interviewed on 11/2/17, at 11:57 a.m. R29's primary physician (MD)-B explained that she does not adjust the antipsychotic medications (used for behaviors and mood) but this decision is made by the geriatric psychiatrist (GP) who orders the medication. MD-B stated staff have not communicated that R29 recently exhibited lethargy symptoms, decrease ability to feed herself and/or decrease in ability to formulate thoughts. MD-B confirmed that further	F 329		

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F 329	Continued From page 41	F 329		

assessment would be conducted.

During an interview on 11/2/17, at 2:08 p.m. registered pharmacist consultant (RPh-C) stated R29 was due to have an attempted dose reduction of antipsychotic medications. Documentation review of the pharmacy note dated 11/2/17, indicated: 11/2/17-Seroquel 200 mg at noon and 100 mg bed time (HS). Present nursing notes are reporting significant decline. Constant daytime lethargy, anorexia, severe edema not controlled by Lasix 40 mg morning and 20 mg afternoon. Neurology psychiatry problems = Alzheimer's dementia hallucinations: anxiety, insomnia, paranoid. Suggest: Immediate dose reduction of Seroquel to 50 mg a.m. and 50 mg midday and 100 mg HS.

When interviewed on 11/3/17, at 10:30 a.m. geriatric psychiatrist (GP) verified being unaware of R29's decline in activities of daily living including the ability to feed herself. Upon providing the observation noted on 11/2/17, where R29 chewed over and over the same mouthful of food, licked at the food and did not recognize she was at the table to eat; GP responded, "No, I knew none of this, nobody told me, she could be going septic". GP further revealed that she was unaware that behavior incidents had decreased in the last three months. GP further stated a reduction in R29's psychoactive medications would be appropriate given her current level of sedation.

During interview on 11/3/17 at 11:58 a.m. registered nurse (RN)-A expressed frustration with MD-B and GP when a review was requested by the consultant registered pharmacist (RPh-C) related to an attempted dose reduction of

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F 329	Continued From page 42	F 329		

antipsychotic medications as both providers would defer to the other party.

Review of R19's record revealed the resident had a history of transient ischemic attacks (temporary stroke), repeated falls and had been diagnosed with dementia in 2014. A Brief Interview for Mental Status (BIMS) dated 9/23/17, identified a score of 6/15, indicating severe cognitive impairment. It was noted that R19 experienced drug-induced hallucinations post hip fracture with surgical repair in September of 2017. As a result, an antipsychotic medication, Seroquel 50 milligrams (mg), had been prescribed by the physician for use at bedtime (HS). On 10/3/17, the physician ordered a dose reduction, to titrate from Seroquel 50 mg to 25 mg and then discontinue after 4 days.

Review of R19's nurse's notes from 10/5/17 through 11/2/17, indicated R19 would yell out for help almost every night. The notes indicated R19 had trouble falling asleep and/or staying asleep throughout the night. Documentation was lacking to indicate staff had assessed the behaviors to determine reasons why R19 called out for help. Documentation showed PRN (as needed) Tylenol (a short acting analgesic medication to treat pain) had been administered to R19 nineteen times throughout the month of October 2017 and that R19 had consistently reported reduced or cessation of pain with the use of the Tylenol.

A nurses' note dated 10/23/17, at 7:19 a.m. indicated R19 had been yelling out, was taken to the bathroom, but had continued yelling. The note indicated R19 had taken off all her clothing and was found lying naked in bed. Staff had transferred R19 to the wheelchair and moved her

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F 329	Continued From page 43 to the nurse's station where she'd reportedly called staff names and was "messing with everything she could get her hands on." On 10/24/17, a physician order for Seroquel 25 mg 1 tablet at noon and 1 tablet at night had been prescribed. The rationale documented indicated the resident experienced: agitation, restlessness, yelling and attempts to self-transfer. A nurse's note entered post administration of Seroquel dated 10/25/17, indicated R19 was lethargic and required an EZ stand (mechanical lift) for transfers because R19 was not supporting herself to stand. Nursing notes documentation indicated R19 continued to yell out for help numerous times between 10/25/17 and 11/2/17. Review of R19's current undated electronic care plan, revealed there were no there were no specific behaviors identified, but nursing staff were to assess and treat pain, identify patterns of behavior, rule out delirium and administer medications as ordered. The care plan also indicated nursing assistants were to maintain the safety of the resident, report pain to the nurse, offer conversation, present tasks one at a time, and redirect when restless and no mention of the behaviors to be reported. Review of the Minimum Data Set (MDS) dated 9/23/17, R19 had no physical, verbal or other behaviors of any kind and had no changes in behavior at the time of the assessments. Observations on 10/31/17, at 12:30 p.m. of R19 indicated she was sitting in her wheelchair in her room, quietly watching her TV. Observation again at 3:30 p.m. revealed R19 was in the hallway outside her room, dressed up for Halloween,	F 329		

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F 329	Continued From page 44 smiling and waiting patiently to pass out candy to trick-or-treaters. Observation on 11/2/17, at 6:39 a.m. indicated R19 was sitting in her wheelchair in her room, asleep. At 6:50 a.m., R19 was awake and now sitting in her wheelchair in the doorway of her room. No behaviors were noted. Later that day at 1:33 p.m., R19 was wheeled by staff to play Bingo, interacting and smiling. Interview on 11/2/17, at 1:34 p.m. with licensed practical nurse (LPN)-B indicated she felt R19 had not fared well behaviorally without the use of Seroquel once it had been discontinued on 10/3/17. R19 was up at night, trying to transfer herself, sitting in hallways, and was known to be anxious. She was restarted on the Seroquel after the 10/23/17, episode as noted above. Interview and document review on 11/2/17, at 1:45 p.m. with the RPh-C indicated he agreed according to the nursing documentation, there was no supporting evidence to show non-pharmacological interventions had been tried prior to initiating R19's antipsychotic Seroquel. The RPh-C stated he felt the root cause of R19's behaviors had not been assessed. The RPh-C stated he documented a note just previous to the interview recommending thyroid laboratory values checked. RPh-C also stated R19 had a complex orthopedic history involving spinal problems that could explain her calling out for help. The RPh-C note dated 11/2/17 revealed the following notations/recommendations: (1) "Seroquel 25 mg BID [twice daily] was restarted on 10/24/17 for agitation, yelling and self	F 329		

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F 329	Continued From page 45 transfer attempts. No psychotic or injurious behaviors were reported." (2) "Problems with sleeping reported. Possible pain syndrome present given history. TSH [thyroid stimulating hormone] was low normal when last measured in May." (3) "Non-med interventions not defined before Seroquel restarted." (4) Suggest: (a) Hold the Seroquel due to lack of a documented indication for use. (b) Recheck thyroid labs. (c) Do pain assessment. (d) Document what non-pharmacological interventions were tried before the Seroquel was ordered. The only policy submitted was the October 2014, Pharmaceutical Services Policies and Procedures which indicated the pharmacist was the only person responsible for conducting chart reviews, performance, and monthly drug regimen reviews. There was no mention of how nursing was to implement non-pharmacological interventions prior to initiating the administration of medication, how behaviors were to be monitored, when the physician was to be notified by nursing staff, how the care plan or medications were to be specific for each resident, or how the interdisciplinary team oversaw the care of the residents with behaviors to maintain their highest emotional and psychological well-being.	F 329		
F 332 SS=E	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or	F 332		12/13/17

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F 332	Continued From page 46 greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly prime the insulin pen prior to administration for 2 of 2 residents (R7, R43) observed and failed to administer a medication according to the physician order for 1 of 1 resident (R43) observed during medication pass. This deficient practice has the potential to affect any resident who received insulin via an insulin pen. Findings include: Observations of medication administration during medication pass were as follows: (1) On 11/1/17, at 11:57 a.m. registered nurse (RN)-C failed to prime the Novolog insulin pen prior to administering 6 units of insulin to R43. (2) On 11/1/17, at 12:03 p.m. RN-C failed to prime the Novolog insulin pen prior to administering 7 units of insulin to R7. (3) On 11/1/17, at 5:41 p.m. licensed practical nurse (LPN)-C failed to prime the Novolog insulin pen prior to administering 7 units of insulin to R7. (4) On 11/2/17, at 7:21 a.m. LPN-B failed to remove the outer and inner cap on the insulin pen prior to priming the pen and administering 6 units of Novolog to R43. (5) On 11/2/17, at 8:15 a.m. RN-C administered Protonix (used for acid reflux) to R25 after the resident had finished breakfast. RN-C noted a discrepancy between the medication blister pack label which indicated the medication was to be administered prior to breakfast; however, the medication administration record (eMAR) made no mention of this. RN-C stated "Its not on here [eMAR] so that's ok." and administered the	F 332	F332 Education and return demonstration training will be provided to the licensed nurses by the Director of Nursing and Unit Coordinator to ensure that each knows how to correctly utilize the insulin pen, including priming it prior to administering the medication. The physician order for R25 was clarified and the Medication Administration Record (MAR) was updated on 11/21/2017. The deficient practice could affect any resident who receives insulin via the insulin pen. As noted above, education and return demonstration training will be provided to the licensed nurses related to the insulin pen. Also, they will review the procedure for seeking clarification and correction of physician orders. The Director of Nursing will be responsible for ensuring that the delivery of insulin via the insulin pens is performed correctly and that each licensed nurse knows how to seek clarification and correction to physician orders. She will complete unannounced audits of the procedure with the licensed nurses to verify their current skill within the next quarter and she will ensure that newly hired licensed nurses receive the correct training. Results of the audits will be	

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F 332	Continued From page 47 medication without checking the physician's order in the medical record. Review of R43's medical record indicated medication orders dated 9/25/17, specifically noted the medication was to be taken every morning before breakfast. When interviewed on 11/2/17, at 7:47 a.m. LPN-B indicated she did not realize she needed to uncap the outer and inner needle prior to priming the flex pen. LPN-B was training RN-C and was not aware RN-C had not been priming any insulin pens prior to administration. Interview on 11/2/17, at 7:58 a.m. with RN-C stated she had not known how to use an insulin pen. She was a new-hire and currently being trained. RN-C explained she had used insulin vials at her previous employment. Interview on 11/2/17, at 12:34 p.m. with the pharmacist regarding R25's medication administration of Protonix indicated the nurse should have verified the order with the medical record to ensure accuracy. Once the error was noted, the physician should be notified of the error and to clarify if it was acceptable to give the medication after or with meals in the future. When interviewed on 11/3/17, at 9:53 a.m. the director of nursing indicated she was unaware of the nurses errors with insulin pen preparation prior to administration. She agreed 5 errors of 25 observations placed the facility at a high medication error rate of 20%. The DON indicated the unit coordinator and/or herself input physician orders into the eMAR when the medication is delivered from the pharmacy. The DON	F 332	reported at the next QAPI committee meeting. Completion Date: December 13, 2017	

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confirmed there is no secondary verification step right to ensure accuracy but she agreed this was an area of concern. The DON's expectation is nursing staff needs to verify and clarify orders prior to administration. The DON further indicated all nursing staff needed re-education on insulin pen preparation and administration.

Review of the revised April 2015 Instructions for Use Novolog FlexPen manufacture's insert indicated after attaching the needle to the insulin pen, staff were to pull off the outer needle cap, then the inner needle cap. They were to turn the dose selector to 2 units. Next, they were to hold the FlexPen with the needle pointing upward and tap the cartridge to remove any air bubbles. While keeping the needle pointing upwards, they were to depress the button until the dose selector returned to zero. Once that was performed they could select the number of units needed to be injected into the resident.

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F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1)	F 425		12/13/17

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced

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F 425	Continued From page 49 by: Based on observation, interview and document review the facility failed to administer medication according to the physician's prescribed order for 2 of 3 residents (R39, R25) reviewed for unnecessary medication. Findings include: R39's quarterly Minimum Data Set (MDS) assessment dated 6/6/17, indicated R39 had short term memory impairment and had a Brief Interview of Mental Status (BIMS) of 4/15-severe cognitive impairment. The MDS also indicated R39 had verbal and physical behaviors 2-6 times during the assessment period. Physician visit note dated 10/3/17, listed diagnoses to include: sexually inappropriate behavior, anxiety, confusion, delusions, insomnia, psychotic disorder and dementia. During an observation on 11/1/17, from 6:09 p.m. to 6:48 p.m. R39 was outside of the bedroom doorway (near the nurses station) and had stood up 12 times setting off personal alarm in the wheelchair. At 7:03 p.m. R39 is observed to be in his bed calling out to have his "head checked to be sure it was still there". The social service progress note dated 10/19/17 10:31 a.m. documented the following: It has become clear that the evenings after supper are the most difficult time to manage and redirect his behaviors. This is probably due to a combination of sundowning, medication wearing off and not having as many staff members available... During review of the psychiatrist progress visit note dated 9/13/17, R39 was to have Seroquel	F 425	F425 The Medication Administration Records (MAR) for R39 and R25 were corrected to match the physician orders. R25's physician was consulted regarding the administration time for the levothyroxine. The physician agreed to change the administration time to match R25's history of when she took the medication at home. All residents could potentially be affected by a transcription error during medication change over at month end. Each licensed nurse and trained medication aide (TMA) will be required to demonstrate comprehension of how to clarify a medication administration order and seek correction if necessary. The policy and procedure for Medication Administration will be reviewed and updated as necessary. The Director of Nursing will be responsible for ensuring that the licensed nurses and TMAs are competent in the skill of medication administration, following physician's orders, and seeking clarification/correction for orders. She will conduct unannounced audits of these skills and provide corrective action as needed for the next quarter. Results will be reported at the QAPI committee meeting in March 2018. Completion Date: December 13, 2017	

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	245522	A. BUILDING ______ B. WING ______	11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

(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 425	Continued From page 50	F 425		

changed to 200 milligrams (mg) daily at HS (bedtime) rather than Seroquel 50 mg in the morning (AM) and 100 mg in the evening (HS), for dementia related behavior, agitation and aggression.

Review of the September 2017 medication administration record (MAR) noted the Seroquel dose was adjusted to be administered at bedtime as ordered by the psychiatrist. However, it was noted that on 9/29/17, the administration time that Seroquel was given was changed from the evening to the morning. Documentation was lacking to indicate the psychiatrist had changed the time to the morning.

During interview on 11/3/17, at 9:48 a.m. registered nurse/nurse manager (RN)-A verified the Seroquel had been ordered to be given at bedtime on 9/13/17. RN-A further verified the change or update to the order occurred 9/29/17, during the monthly medication change. RN-A explained the nurse updating the MAR changed/updated the computer order to reflect the directions on the label of the medication card rather than checking the current physician order. RN-A verified the medication was not administered as ordered (HS). She indicated she initiated the medication error process and notified the psychiatrist of the error.

During medical record review the physician order dated 9/25/17, identified R25 should receive 75 micrograms (mcg) of levothyroxine, a medication used to treat low thyroid, every morning on an empty stomach, 30-60 minutes before breakfast. Review of the eMar indicated the order had been changed to "Give at PM per daughter-in-law. She says this is how she wants [R25] to continue to

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F 425	Continued From page 51 take this, in case she returns home." There was no indication the physician had been consulted to determine whether the change in time was acceptable. Interview on 11/2/17, at 12:34 p.m. with the registered consulting pharmacist (RPh-C) confirmed that once an error related to administration time is identified, the physician should be notified to clarify whether the medication should be administered different from the order. Interview on 11/3/17, at 9:53 a.m. the DON indicated it was the expectation that staff clarify physician orders prior to administration of medications and that discrepancies should be discussed and reported with the physician.	F 425		
F 441 SS=F	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);	F 441		12/13/17

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F 441	Continued From page 52 (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 441		

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F 441	Continued From page 53 (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a risk assessment and policies were completed related to prevention of Legionella contamination of their water supply and management of potential Legionella outbreaks. This deficient practice had the potential to affect all 45 residents residing in the facility. In addition, the facility failed to ensure proper hand hygiene was implemented during personal cares for 1 of 1 resident (R29) observed during evening cares. Findings include: During interview on 10/31/17, at 8:50 a.m. the administrator stated "I do not think we have done an assessment," related to Legionella vulnerability with water supply, and referred survey staff to the maintenance supervisor (MS). During interview on 11/3/17, at 8:37 a.m. the MS stated he thought the administrator was supposed to be the lead on the Legionella assessment and policies, and was not sure what had been completed at this time. During interview on 11/3/17, at 12:52 p.m. the director of nursing (DON) confirmed she had spoken with the administrator and the facility	F 441	F441 The Water Management Plan that addresses procedures that reduce the growth and spread of Legionella will be completed on or before December 13, 2017. As stated in the plan, environmental testing will be completed if the facility has difficulty maintaining the building's water systems within the control limits. The Director of Nursing met with the staff member who provided cares to R29 to review proper hand hygiene procedures. R29 is no longer affected by this practice as she expired on 11/15/17. All residents are potentially affected by these named practices. As it is, LMH's Water Management Plan has determined that its water systems and practices are intact and do not promote the growth of Legionella or any other opportunistic pathogen. All staff education which addressed the topic of hand washing was presented on 10/18/2017 by the Director of Nursing. The Director of Nursing and her delegates	

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F 441	Continued From page 54 lacked a completed Legionella risk assessment for their water supply as well as completed policies related to potential outbreaks. R29's Diagnosis list dated 9/27/17, identified osteomyelitis of right great toe, cellulitis of right distal lower limb, chronic renal insufficiency, heart failure, edema, and Alzheimer's disease. R29's annual Minimum Data Set (MDS), dated 10/14/17 indicated resident is rarely understood, had difficulty focusing attention. The MDS also indicated R29 experienced a decline in activities of daily living and was extensive assist of two for all areas of activities of daily living, and had a diabetic foot ulcer, which required application of dressings to the feet. During observation of evening cares on 11/1/17, at 7:05 p.m. with nursing assistant (NA)-B and NA-C the following was noted: -At 7:05 p.m. NA-B and NA-C attempted to stand R29 with the use of a gait belt. R29 winced and was unable to stand and bear weight on her lower extremities, which were edematous. NA-B and NA-C then utilized a standing mechanical lift (EZ stand) and transferred R29 onto the toilet. After R29 voided, NA-B proceeded to complete hygiene of the peri area as R29 had been incontinent of soft stool. NA-B wiped R29's peri-area using one wash cloth. Without removing soiled gloves and/or hand washing, NA-B proceeded to dry the peri area and then the buttocks with a clean, dry towel. After completion of incontinent cares, NA-B and NA-C proceeded to transfer R29 into the wheelchair. NA-B touched the lift handles of the EZ stand with soiled gloves. During the transfer process, NA-B touched surfaces on the lift, sling, sink, wheel chair and	F 441	will remain responsible for ensuring that infection control measures such as handwashing is being demonstrated accurately by her staff. She will delegate the responsibility to the other department directors to ensure that their staff are following the agreed upon procedures based on Universal Precautions. Annual re-education will continue for all staff. The Administrator and Environmental Services Director will continue to be responsible for the Water Management Plan. Unannounced hand hygiene audits will be conducted across departments for the next quarter by the Director of Nursing and her delegates with the results reported at the QAPI Committee meeting in March 2018. Corrective action will be taken as needed. Completion Date: December 13, 2017	

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F 441	Continued From page 55	F 441		

Continued From page 55

the handles on R29's wheelchair. When questioned by the surveyor regarding the lack of removing soiled gloves, NA-B confirmed the soiled gloves had not been removed nor had handwashing occurring after cleansing stool and urine and providing personal cares for R29. NA-B verified cares were completed with soiled gloves and were not removed prior to assisting R29 with transfer to the wheelchair.

NA-B failed to remove the soiled gloves after being questioned about poor technique and continued to wear them.
- At 7:10 p.m. NA-B prepared a toothbrush and handed the item to R29, who proceeded to brush her teeth while seated near the sink. Upon completion of oral care, NA-B wheeled R29 to the bedside and assisted with dressing, which included applying lotion to arms, back and legs prior to applying pajamas. NA-B and NA-A transferred R29 into bed. NA-B assisted R29 by lifting her legs onto the bed as she was unable to independently perform this movement. At this time, the surveyor again questioned NA-B about the continued use of soiled gloves. NA-B confirmed the soiled gloves had not yet been removed. NA-B verified the gloves should have been removed, hand washing implemented and new clean gloves applied immediately after cleansing an incontinent bowel movement from R29's peri-area.
- At 7:25 p.m., NA-B confirmed he received infection control training related to handwashing and glove use during his nursing assistant courses.

When interviewed on 11/2/17, at 12:53 p.m. the director of nursing (DON), who was also the infection control coordinator, confirmed proper

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F 441		F 441		

Continued From page 56
infection control had not been implemented per facility expectations during described care for R29. The DON verified NA-B should have removed the soiled gloves and washed his hands after completing incontinence care.

The facility policy last revised 10/11/17, and titled Handwashing indicated: Employees will observe standard precautions throughout the facility to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid type is difficult or impossible, all bodily fluids will be considered potentially infectious materials.
Guidelines:
-The use of gloves does not replace handwashing
- A waterless antiseptic solution may be used as a adjunct to routine handwashing.
- When antiseptic solutions are used, hands should be washed as soon as feasible following their use.
handwashing:
All employees will wash their hands using soap, running water, and friction in the following situations:
1. At the beginning and end of the work shift.
2. Immediately after or as soon as feasible following contact with blood or other potentially infectious materials
3. Immediately or as soon as feasible after removal of gloves or other personal protective equipment.
4. Whenever hands are obviously soiled.
5. When performing invasive procedures.
6. Before preparing or handling medications.
7. After prolonged contact with a resident.
8. After handling used dressings, specimen containers, contaminated tissues, linen, etc,
9. After handling items or work surfaces

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F 441	Continued From page 57 potentially contaminated with residents blood excretions or secretions. 10. After using the toilet, blowing/wiping nose, smoking, combing hair etc. 11. Before and after eating 12. When in doubt, and 13. Upon completion of duty.	F 441		
F 456 SS=D	ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION CFR(s): 483.90(d)(2)(e) (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safety tabs were checked and maintained according to manufacturer's guidelines for 3 of 3 EZ-Care stand lifts reviewed. This has the potential to affect any resident who required the use of the EZ Way Smart Stand. Findings include: Review of the undated EZ Way Smart Stand Operator's Instructions, EZ Way Smart Stand® Safety & Maintenance Checklist, indicated the following components and operating points be scheduled for inspection at intervals not greater than one month. Any detected deficiency must be rectified before the stand is put back into service.	F 456	F456 The safety tabs were replaced on the EZ Machines by the Maintenance Supervisor (MS) during the survey process. Additional tabs were ordered and will be stored in a place that the nurses have access. A routine safety inspection will be completed by the Maintenance Director or his designee on a monthly basis which will include ensuring that the safety tabs are in place and functional. The RN Unit Coordinator and MS will be responsible for ensuring that this activity is completed and sustained. Safety audits will continue and results reported to the safety committee on a quarterly basis.	12/13/17

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Safety tabs need to be checked to make sure they are in place.

Observation and interview on 11/1/17 at 7:15 p.m. of nursing assistant (NA)-D attempting to transfer R21 from her wheelchair to her bed revealed NA-D proceeded to place the strap around R21's back and placed the loops from that strap into the mechanical lift (#1) on each side. The left side of the mechanical lift had a rubber safety tab that was positioned away from the mechanical lift loop. The right side of the lift had no safety tab at all and was unaware of the location of additional tabs. NA-D left the room and questioned licensed practical nurse (LPN)-C the location where the safety tabs were stored. LPN-C responded that only maintenance had them and instructed NA-D to find a mechanical lift which had both safety tabs attached before attempting to transfer R21 and/or another resident.

Observation 11/1/17, at 8:00 p.m. of the mechanical lift (#2) located on the east nurses station hallway had no safety tabs noted on the lift.

Observation on 11/1/17, at 8:05 p.m. in the middle hallway revealed there was another mechanical lift (#3)with one safety tab missing.

Interview on 11/2/17, at 10:45 a.m. with the maintenance supervisor (MS) indicated he put new tabs on the mechanical lifts today when he became aware they were off the equipment and ordered additional tabs. MS indicated he had not been informed they were missing. MS confirmed he stores the tabs in his office, which is locked and staff do not have access, especially after hours.

Correction Date: December 13, 2017

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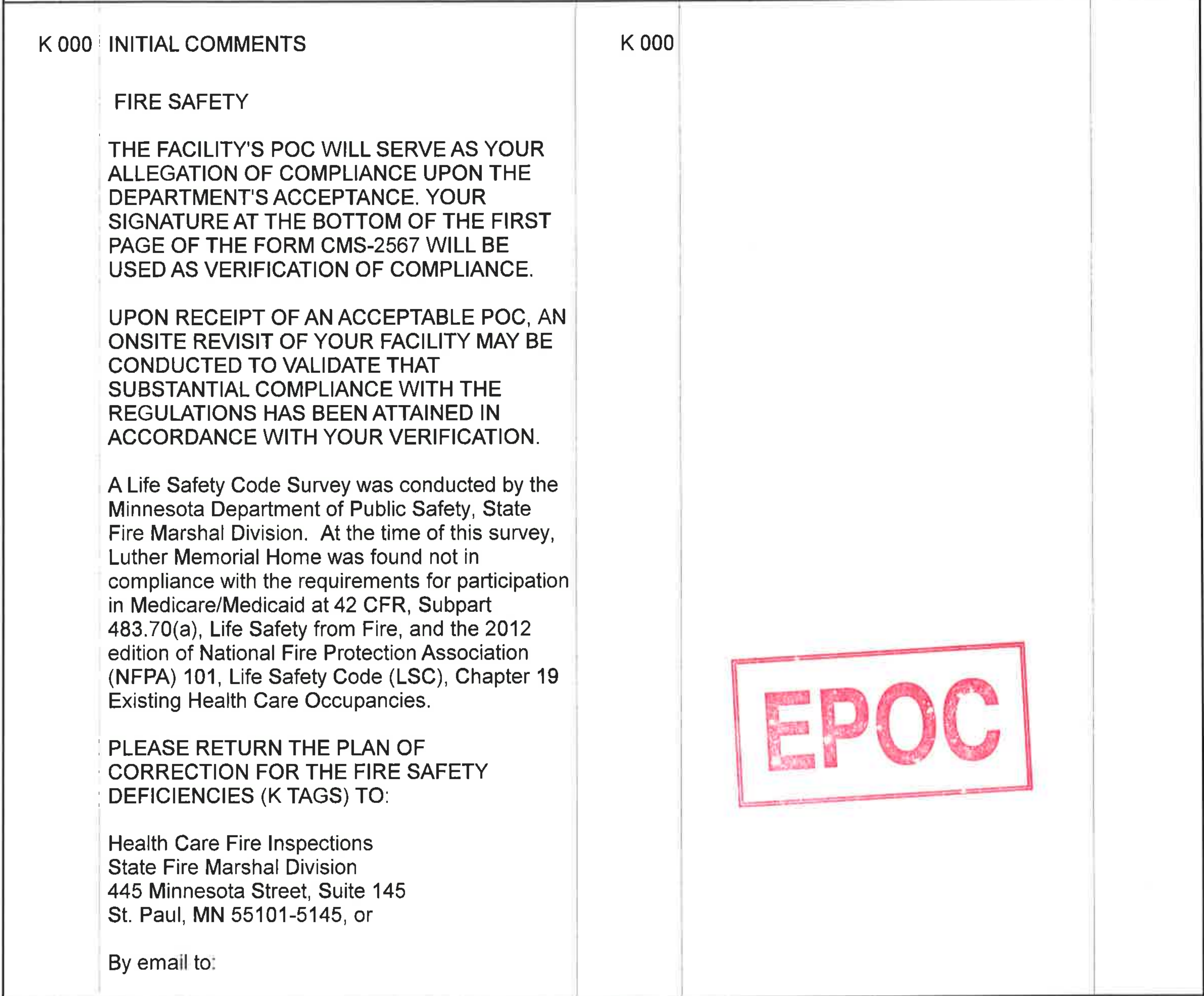
F 456	Continued From page 59 No policy related to routine safety checks of the mechanical lift equipment was submitted.	F 456		

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

T5522027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**11/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST** **MADELIA, MN 56062**



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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 FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Luther Memorial Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/30/2017

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

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K 000	Continued From page 1	K 000		

Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Luther Memorial Home was constructed as follows:
The original building was constructed in 1958, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 1st addition was constructed in 1973, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 2nd addition was constructed in 1993, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction.
The 3rd addition was constructed in 2001, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction.

The facility has a fire alarm system with smoke detection throughout the corridor system. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 51 beds and had a census of 44 at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/01/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST** **MADELIA, MN 56062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 time of survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that exit and directional signs are displayed in accordance with 7.10 Exit Signage.This deficient practice could affect 44 out of 44 residents. 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 11/01/2017, several exit signs were observed not illuminated. These exit signs were at the following locations:	K 293	K293 The identified exit signs were replaced and are illuminated. The Environmental Services Director and his delegates will maintain responsibility for ensuring that the signs are functioning according to the regulation/standard. Correction Date: November 20, 2017	11/20/17

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/01/2017**

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K 293	Continued From page 3 Maplewood Hallway Exit to Staff Dining Room, Dining Room Exits, Front Desk Exit and the Main Entrance Exit. NOTE: All exit signs need to be inspected to ensure they are all illuminated. This deficient practice was verified by the Facility Maintenance Director.	K 293		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________ b) Who provided system test _____________ c) Water system supply source _____________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 44 out of 44 residents.	K 353	K353 The fire sprinkler system will be inspected and tested on 12/1/2017 and quarterly thereafter either by a vendor or by a trained LMH staff member.	12/13/17

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	245522	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/01/2017

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K 353	Continued From page 4 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ____________________ b) Who provided system test ____________________ c) Water system supply source ____________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 11/01/2017, observation revealed that documentation could not be provided that showed that the fire sprinkler system had been inspected and tested on a quarterly basis during 2017. This deficient practice was verified by the Facility Maintenance Director.	K 353	The Environmental Services Director will maintain responsibility for ensuring that this test is completed and documented each quarter. Completion Date: December 13, 2017	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		12/13/17

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K 918	Continued From page 5 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of generator maintenance and testing. This deficient practice could affect 44 of 44 residents. Electrical Systems - Essential Electric System	K 918	K918 Annual maintenance on the emergency generator was completed on 11/20/2017. The monthly generator load test had been conducted for all months from February	

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K 918	Continued From page 6 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 11:00 AM and 3:00 PM on 11/01/2017, during documentation review, it was revealed that a monthly generator load test was not conducted in January, 2017 and	K 918	2017 to December 2017. Documentation of the tests is available for inspection. The Environmental Services Director and his delegates will maintain responsibility for arranging for the annual maintenance of the emergency generator and maintaining the supporting documentation to prove that it occurred. Also, this director will be responsible for ensuring that the load tests and documentation are completed. Completion Date: December 13, 2017	

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K 918	Continued From page 7 documentation could not be located to show that annual maintenance had occurred on the emergency generator. This deficient practice was verified by the Facility Maintenance Director.	K 918		

Electronically delivered
November 21, 2017

Ms. Dawn Campbell, Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

Re: State Nursing Home Licensing Orders - Project Number S5522028

Dear Ms. Campbell:

The above facility was surveyed on October 31, 2017 through November 3, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period for Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie, Unit Supervisor at 507-476-4233 or at kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00695	A. BUILDING: ______ B. WING ______	11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST MADELIA, MN 56062**

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 31st, November 1st, 2nd, 3rd, 2017, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		12/13/17

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician of symptoms of daytime lethargy, anorexia, and severe edema for 1 of 1 resident (R29) reviewed who experienced a significant decline in activities of daily living and deteriorating medical condition. Findings include: The cumulative diagnosis list updated 9/27/17, identified diagnoses including: type 2 diabetes mellitus, osteomyelitis of right great toe, cellulitis right distal lower limb, chronic renal insufficiency, heart failure, edema and Alzheimer's disease. The annual Minimum Data Set (MDS) assessment dated 10/14/17, indicated R29 is rarely understood and had difficulty focusing attention. The MDS also indicated R29 experienced a decline in activities of daily living (ADL) and required extensive staff assist of two. The MDS revealed R29 received scheduled pain medication and had diabetic foot ulcers which required application of dressings to feet. The care plan last revised 10/24/17, indicated R29 had severe and moderate cognitive impairment-Report change in physical condition and appetite. The physician orders dated 8/8/17, indicated R29 received Seroquel 200 mg mid-day and 100 mg daily at bedtime for resistive behaviors, aggression and agitation towards staff.	2 265	corrected	

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2 265	Continued From page 4	2 265		

Review of nursing notes dated 10/11/7 through 10/26/17, identified that R29 exhibited a decline in appetite and ability to eat, little energy, feeling tired, lethargy and increase in confusion.

During observation in the dining room on 11/2/17, at 8:24 a.m. R29 was seated at the dining table. Nursing assistant (NA)-A placed a bite of corn flakes soaked in milk in R29's mouth. R29 chewed the cornflakes repeatedly, not swallowing. NA-A asked R29 "are you going to wake up to eat?" R29 with eyes closed said "oh my food is here?" R29 was sitting with her eyes half open attempting to focus. R29 picked up her glass and took 2 sips. It was noted her head was hanging. When the surveyor questioned R29 how she was, she responded "not ok, I'll be better tomorrow" R29 proceeded to fall asleep. Interview with NA-A at this time revealed R29 had been feeding herself after set up, until approximately two weeks ago; however, now when staff tried to get her to eat she would only lick at the food on the spoon, or chew and chew.

When interviewed on 11/2/17, at 11:57 a.m. R29's primary physician (MD)-B explained that have not communicated that R29 recently exhibited lethargy symptoms, decrease ability to feed herself and/or decrease in ability to formulate thoughts. MD-B confirmed that further assessment would be conducted.

Documentation review of the pharmacy note dated 11/2/17, indicated: 11/2/17-Seroquel 200 mg at noon and 100 mg bed time (HS). Present nursing notes are reporting significant decline. Constant daytime lethargy, anorexia, severe edema not controlled by Lasix 40 mg morning and 20 mg afternoon. Neurology psychiatry

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2 265	Continued From page 5	2 265		

problems = Alzheimer's dementia hallucinations: anxiety, insomnia, paranoid. Suggest: Immediate dose reduction of Seroquel to 50 mg a.m. and 50 mg midday and 100 mg HS. Immediate pain assessment addressing painful edematous feet and osteomyelitis pain. Currently only Tylenol 1000 mg bedtime is ordered.

When interviewed on 11/3/17, at 10:30 a.m. geriatric psychiatrist (GP) verified being unaware of R29's decline in activities of daily living including the ability to feed herself. Upon providing the observation noted on 11/2/17, where R29 chewed over and over the same mouthful of food, licked at the food and did not recognize she was at the table to eat; GP responded, "No, I knew none of this, nobody told me, she could be going septic". GP further revealed that she was unaware that behavior incidents had decreased in the last three months. GP further stated a reduction in R29's psychoactive medications would be appropriate given her current level of sedation.

A policy was requested for notification of change to the physician on 11/3/17, none was provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing could ensure all staff are educated on recognizing and reporting changes in resident condition. The director of nursing and medical director could develop policies and procedures related to coordinating care between attending physicians and consulting medical practitioners, to ensure they are aware of underlying medical conditions and/or symptoms that may affect treatment and educate staff on these changes. The director of nursing or designee could audit resident charts for changes

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 6 in condition, and report results of the audits to the quality assurance committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise and individualize the care plan for 1 of 1 resident (R19), who experienced behavioral symptoms and was on an antipsychotic medication (Seroquel) for behaviors. Findings include: Review of R19's physician orders dated 10/3/17, the primary care provider ordered to titrate (reduce) the dose from Seroquel 50 mg to 25 mg and discontinue after 4 days.	2 570	corrected	12/13/17

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2 570	Continued From page 7	2 570		

Review of R19's nurse's notes from 10/5/17 through 11/2/17 indicated R19 would yell out for help almost every night. R19 was noted to have trouble falling asleep or staying asleep throughout the night.

The nurses notes dated 10/23/17, at 7:19 a.m. documented that R19 yelled out, was taken to the bathroom but was continued yelling out. R19 had taken off all her clothing and was found lying naked in bed. R19 was transferred to a wheelchair and brought from her room to the nurse's station where she reportedly called staff names and was "messing with everything she could get her hands on."

Review of R19's current undated electronic care plan indicated there were no interventions specific to behaviors listed on the care plan. Nursing staff were only to identify triggers and underlying causes of behavior, but there were no specific behaviors noted. Nursing staff were to assess and treat pain, identify patterns of behavior, and rule out delirium, and administer medications as ordered. There was no mention of any behavioral interventions for R19. Nursing assistants were to maintain the safety of the resident, report pain to the nurse, offer conversation, present tasks one at a time, and redirect a restless resident. There was no mention on what types of behaviors the resident had or what types of behaviors needed to be reported to the nurse.

Review of the Minimum Data Set dated 9/23/17, indicated R19 had no physical, verbal or other behaviors of any kind and had no changes in behavior at the time of those assessments.

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2 570	Continued From page 8	2 570		

Observations on 10/31/17, at 12:30 p.m. of R19 indicated she was sitting in her wheelchair in her room, quietly watching her TV. Observation again at 3:30 p.m. revealed R19 was in the hallway outside her room, dressed up for Halloween, smiling and waiting to pass out candy to trick-or-treaters.

Observation on 11/2/17, at 6:39 a.m. indicated R19 was sitting in her wheelchair in her room, asleep. At 6:50 a.m., R19 was awake and now sitting in her wheelchair in the doorway of her room. No behaviors were noted. Later that day at 1:33 p.m., R19 was observed being wheeled to bingo by staff and interacting well and smiling.

Interview on 11/02/17, at 1:34 p.m. with licensed practical nurse (LPN)-B indicated she felt R19 had not fared well behaviorally without the use of Seroquel once it had been discontinued on 10/3/17. R19 was up at night, trying to transfer herself, sitting in hallways, and was known to be anxious. She was restarted on the Seroquel after the 10/23/17, episode as noted above.

Interview and document review on 11/2/17, at 1:45 pm with pharmacist-B indicated he agreed according to the nursing documentation, there was no supporting evidence to show non-pharmacological interventions had been tried first prior to initiating R19's antipsychotic Seroquel. Furthermore, he felt an assessment had not been conducted related to the root cause of R19's behaviors. He indicated he made a note just previous to our interview and recommended to check her thyroid laboratory values to see whether it was within normal limits. He also stated R19 had a complex orthopedic history involving spinal problems that he felt may explain her calling out for help.

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2 570	Continued From page 9 Document review of the revised February 2017, Care Planning and Care Conference policy indicated Luther Memorial Home will work with each individual resident and their families/designee to develop a plan of care that all are in agreement with. The care plan will be reviewed quarterly with the interdisciplinary team, the resident or resident's representative and staff. Corrections will be made to the plan of care as needed. Care plans are an on going process and will have updates made on as-needed basis with any changes. The care plan will be reviewed and updated as appropriate for a new admission, a resident who returns from a hospital, or has a significant change of condition. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate all staff related to care plan revisions and audit resident charts to ensure timely edits are occurring to ensure an accurate care plan. The director of nursing or designee could report results of the audits to the quality assurance committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and	2 830		12/13/17

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2 830	Continued From page 10 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure mechanical lifts were properly equipped with a safety tab for 1 of 2 residents (R21) observed who were transferred using a mechanical lift for mobility and failed to ensure bedrails had been assessed for safety for 5 of 5 residents (R25, R29, R35, R39, R50) reviewed for accidents. Findings include: Observation and interview on 11/1/17 at 7:15 p.m. of nursing assistant (NA)-D attempting to transfer R-21 from her wheelchair to her bed revealed NA-D proceeded to place the strap around R21 back, and placed the loops from that strap into the mechanical lift on each side. The left side of the mechanical lift had a rubber safety tab that was positioned away from the mechanical lift loop. The right side of the lift had no safety tab at all. NA-D then attempted to lift R21 up from her wheelchair before being stopped by this surveyor for safety. NA-D was unsure what the rubber tab was located on the left side, it's purpose nor reason it was facing away from the loop of the mechanical lift. NA-D was unaware where staff stored additional tabs. NA-D left the room and questioned licensed practical nurse (LPN)-C the location where the safety tabs were stored.	2 830	corrected	

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LPN-C responded that only maintenance had them and instructed NA-D to find a mechanical lift which had both safety tabs attached before attempting to transfer R21 and/or another resident.

Further interview on 11/1/17, at 7:20 p.m. with LPN-C indicated she was unaware staff had been using the mechanical lifts without the necessary safety tabs; a resident safety.

Observation 11/1/17, at 8:00 p.m. of the mechanical lift located on the east nurses station hallway had no safety tabs noted on the lift.

Interview on 11/1/17, at 8:02 p.m. with NA-F indicated she used that mechanical stand lift to transfer one [unidentified] resident tonight without the safety tabs attached. NA-F was unaware whether extra safety tabs were available and unaware the lift should not be used without the appropriate safety attachments.

Observation on 11/1/17, at 8:05 p.m. in the middle hallway revealed there was another mechanical lift with one safety tab missing.

Interview on 11/2/17, at 10:20 am with the management consultant indicated his expectation was staff were to not use the lifts without the appropriate safety tabs in place.

Interview on 11/2/17, at 10:45 a.m. with the maintenance supervisor (MS) indicated he put new tabs on today when he became aware they were off and ordered additional tabs. MS was not told by staff they were missing. MS keeps the tabs in his office. MS's office is locked and staff have no way to access those safety tabs if it is after hours.

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2 830	Continued From page 12	2 830		

Interview on 11/3/17, at 10:02 a.m. with the director of nursing indicated her expectation was staff were to ensure safety tabs were on mechanical lifts prior to use for patient safety.

Review of the undated EZ Way Smart Stand Operator's Instructions, EZ Way Smart Stand® Safety & Maintenance Checklist, indicated the following components and operating points be scheduled for inspection at intervals not greater than one month. Any detected deficiency must be rectified before the stand is put back into service. Safety tabs need to be checked to make sure they are in place.

During observations on 10/31/17, at 1:19 p.m. and again at 3:10 p.m. R50 had both top half bedrails in the up position while he was resting in bed. On 11/1/17, at 11:14 a.m. an interview was attempted with R50 while he laid in bed; however, due to his terminal illness of cancer, he could not answer and was unable to make his needs known, but was observed to move on his own from side to side within the bed.

Document review indicated R50 was admitted on 8/8/17, with an active diagnosis of lung cancer which had metastasis to brain and other organs. The admission Minimum Data Set dated 8/15/17, and the significant change MDS (hospice) dated 9/27/17, both indicated he was rarely understood when interviewed.

Review of the bed rail assessment for R50 indicated, "Alert and oriented x 3 during day," and not "Confused at night."; and "Resident wants side rails." The team recommended bedrails be placed for R50 at all times while he was in bed. "Resident requests side rails."

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2 830	Continued From page 13 The quarterly Minimum Data Set (MDS) assessment dated 8/22/17, identified R39 had severe cognitive impairment, diagnoses of dementia and anxiety and required extensive physical assistance from staff for activities of daily living (ADLs) including transfer and bed mobility. During an observation on 11/1/17, at 7:03 p.m. R39 was resting on the bed with the quarter bedrail in the raised position on the open side of the bed with the other side of bed placed up against the wall. Gaps were noted in Zones 2 and 4 of the bedrail. The MDS dated 10/14/17, identified R29 had severe cognitive impairment, diagnoses to include Alzheimer's disease and required physical assistance from facility staff for activities of daily living (ADLs) including transfer and bed mobility. During an observation on 10/31/17, at 1:47 p.m. R29 was resting on the bed with bilateral quarter bedrail's in the raised position. R25's admission MDS dated 10/2/17, identified a Brief Interview for Mental Status score of 9/15, indicating moderate cognitive impairment. R25 required supervision and setup with bed mobility and was extensive assistance of one staff member for transfers. During observation and interview on 10/31/17, at 1:04 p.m. R25 was observed to have a raised quarter bedrail on the left side of her bed which was elevated. The bedrail had large gaps in Zone 2 and Zone 4, and was wobbly when grasped and lightly shaken. R25 denied using the rail for bed mobility and stated, "Why would I use that anyway to get in and out of bed, it is shaky?"	2 830		

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The quarterly MDS dated 8/28/17, identified R35 had moderate cognitive impairment, diagnoses to include Alzheimer's disease and required physical assistance from facility staff for activities of daily living (ADLs) including transfer and bed mobility.

R35's side rail assessment, dated 3/21/17 indicated she was safe to have a bedrail up on the right side of the bed; however, did not contain an assessment of the safety of the bedrail within recommended dimensional limits.

During an observation on 10/31/17, at 10:28 a.m. R35 was resting on the bed with the quarter bedrail in the raised position on the open side of the bed with the other side of bed placed up against the wall. Gaps were noted in Zones 2 and 4 of the bedrail.

During interview on 11/3/17, at 12:42 p.m. the director of nursing (DON) stated they had assessed rails in the past to determine whether or not they used as a restraint device, but it was a "Good point," to assess them for safety including proper dimensional limits. She verified the current bedrail assessments had not included determining whether they were within recommended dimensional limits, and thought maintenance had addressed this.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could develop policies and procedures related to the assessment of residents for changes in condition, and educate staff on the changes. The director of nursing or designee could audit resident charts for changes in condition with respect to nursing care and follow-up response, and report results of the audits to the quality assurance committee. Additionally, the director of nursing or designee

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2 830	Continued From page 15 could review and revise policies with respect to bed rails to ensure bed rail assessments include measurements documenting they do not exceed dimensional limits recommended by the Food and Drug Administration. The director of nursing or designee could audit resident bed rails and their assessment documentation periodically, and report findings to the quality assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as	21390		12/13/17

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21390	Continued From page 16 disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure proper hand hygiene was implemented during personal cares for 1 of 1 resident (R29) observed during evening cares. Findings include: R29's Diagnosis list dated 9/27/17, identified osteomyelitis of right great toe, cellulitis of right distal lower limb, chronic renal insufficiency, heart failure, edema, and Alzheimer's disease. R29's annual Minimum Data Set (MDS), dated 10/14/17 indicated resident is rarely understood, had difficulty focusing attention. The MDS also indicated R29 experienced a decline in activities of daily living and was extensive assist of two for all areas of activities of daily living, and had a diabetic foot ulcer, which required application of dressings to the feet. During observation of evening cares on 11/1/17, at 7:05 p.m. with nursing assistant (NA)-B and NA-C the following was noted: -At 7:05 p.m. NA-B and NA-C attempted to stand R29 with the use of a gait belt. R29 winced and was unable to stand and bear weight on her lower extremities, which were edematous. NA-B and NA-C then utilized a standing mechanical lift (EZ stand) and transferred R29 onto the toilet. After R29 voided, NA-B proceeded to complete	21390	corrected	

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21390	Continued From page 17 hygiene of the peri area as R29 had been incontinent of soft stool. NA-B wiped R29's peri-area using one wash cloth. Without removing soiled gloves and/or hand washing, NA-B proceeded to dry the peri area and then the buttocks with a clean, dry towel. After completion of incontinent cares, NA-B and NA-C proceeded to transfer R29 into the wheelchair. NA-B touched the lift handles of the EZ stand with soiled gloves. During the transfer process, NA-B touched surfaces on the lift, sling, sink, wheel chair and the handles on R29's wheelchair. When questioned by the surveyor regarding the lack of removing soiled gloves, NA-B confirmed the soiled gloves had not been removed nor had handwashing occurring after cleansing stool and urine and providing personal cares for R29. NA-B verified cares were completed with soiled gloves and were not removed prior to assisting R29 with transfer to the wheelchair. NA-B failed to remove the soiled gloves after being questioned about poor technique and continued to wear them. - At 7:10 p.m. NA-B prepared a toothbrush and handed the item to R29, who proceeded to brush her teeth while seated near the sink. Upon completion of oral care, NA-B wheeled R29 to the bedside and assisted with dressing, which included applying lotion to arms, back and legs prior to applying pajamas. NA-B and NA-A transferred R29 into bed. NA-B assisted R29 by lifting her legs onto the bed as she was unable to independently perform this movement. At this time, the surveyor again questioned NA-B about the continued use of soiled gloves. NA-B confirmed the soiled gloves had not yet been removed. NA-B verified the gloves should have been removed, hand washing implemented and new clean gloves applied immediately after	21390		

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cleansing an incontinent bowel movement from R29's peri-area.
- At 7:25 p.m., NA-B confirmed he received infection control training related to handwashing and glove use during his nursing assistant courses.

When interviewed on 11/2/17, at 12:53 p.m. the director of nursing (DON), who was also the infection control coordinator, confirmed proper infection control had not been implemented per facility expectations during described care for R29. The DON verified NA-B should have removed the soiled gloves and washed his hands after completing incontinence care.

The facility policy last revised 10/11/17, and titled Handwashing indicated: Employees will observe standard precautions throughout the facility to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid type is difficult or impossible, all bodily fluids will be considered potentially infectious materials.
Guidelines:
-The use of gloves does not replace handwashing
- A waterless antiseptic solution may be used as a adjunct to routine handwashing.
- When antiseptic solutions are used, hands should be washed as soon as feasible following their use.
handwashing:
All employees will wash their hands using soap, running water, and friction in the following situations:
1. At the beginning and end of the work shift.
2. Immediately after or as soon as feasible following contact with blood or other potentially infectious materials
3. Immediately or as soon as feasible after

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 19 removal of gloves or other personal protective equipment. 4. Whenever hands are obviously soiled. 5. When performing invasive procedures. 6. Before preparing or handling medications. 7. After prolonged contact with a resident. 8. After handling used dressings, specimen containers, contaminated tissues, linen, etc, 9. After handling items or work surfaces potentially contaminated with residents blood excretions or secretions. 10. After using the toilet, blowing/wiping nose, smoking, combing hair etc. 11. Before and after eating 12. When in doubt, and 13. Upon completion of duty. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit resident cares for appropriate hand hygiene, and educate all direct caregivers on proper technique. The director of nursing or designee could report findings of the audits to the quality assurance committe for follow up to ensure ongoing compliance. The administrator or designee could complete a risk assessment of the facility water supply for susceptibility to Legionella contamination, and develop policies related to Legionella prevention and outbreak management and educate all staff on the the policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An	21535		12/13/17

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21535	Continued From page 20 unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and evaluate the need to reduce an antipsychotic medication dose and/or failed to implement non-pharmacological interventions and assess for alternative causes of behavior prior to administration of an antipsychotic medications (Seroquel) for 2 of 5 residents (R29, R19) reviewed for unnecessary medications. Findings include: The cumulative diagnosis list for R29, updated 9/27/17, identified diagnoses including: type 2 diabetes mellitus, osteomyelitis of right great toe,	21535	corrected	

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cellulitis right distal lower limb, chronic renal insufficiency, heart failure, edema and Alzheimer's disease.

The annual Minimum Data Set (MDS) assessment dated 10/14/17, indicated R29 is rarely understood and had difficulty focusing attention. The MDS also indicated R29 experienced a decline in activities of daily living (ADL) and required extensive staff assist of two. The MDS revealed R29 received scheduled pain medication and had diabetic foot ulcers which required application of dressings to feet.

The care plan last revised 10/24/17, indicated R29 had severe to moderate cognitive impairment-Psychotropic medications, nurses-monitor for adverse effects, irritability, psychomotor slowing. Report change in physical condition and appetite.

The physician orders dated 8/8/17, indicated R29 received Seroquel 200 milligrams (mg) mid-day and 100 mg daily at bedtime (HS) for resistive behaviors, aggression and agitation towards staff.

Review of nursing notes dated 10/11/17 through 10/26/17, identified that R29 exhibited a decline in appetite and ability to eat, had little energy, experienced feeling tired, and had an increase in confusion.

Review of physician visit notes dated 10/24/17, indicated R29 had a chronic wound on right great toe medial aspect which had been diagnosed as osteomyelitis. The note indicated R29's family had chosen not to treat, recognizing the risks, and that bilateral leg swelling had worsened. In addition, the physician noted R29 was significantly confused due to dementia. The

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prescribed plan included: It is possible to increase her diuretics but that would cause profound hypokalemia which might cause cardiac issues. For that reason I did not make changes in medications. Suggested leaving her legs elevated as much as possible. We are not actively treating her osteomyelitis. It is possible this pt. (patient) [R20] would have septic issues down the road. Currently we are managing medications at minimal level to make her symptomatically comfortable. Therefore I would not start any active treatment. The physician's progress note documentation was lacking any indication an assessment related to the current dose of Seroquel had been addressed and/or reviewed.

When interviewed on 11/2/17, at 7:27 a.m. nursing assistant (NA)-E revealed R29 seemed to be tired more recently and the nursing assistants had been transferring R29 from one surface to another with a standing lift. NA-E confirmed that during cares R29 would try to grab and to hit out; however, the incidents are fewer.

During observation in the dining room on 11/2/17, at 8:24 a.m. R29 was seated at the dining table. Nursing assistant (NA)-A placed a bite of corn flakes soaked in milk in R29's mouth. R29 chewed the cornflakes repeatedly, not swallowing. NA-A asked R29 "are you going to wake up to eat?" R29 with eyes closed said "oh my food is here?" R29 was sitting with her eyes half open attempting to focus. R29 picked up her glass and took 2 sips. It was noted her head was hanging. When the surveyor questioned R29 how she was, she responded "not ok, I'll be better tomorrow." R29 proceeded to fall asleep. Interview with NA-A at this time revealed R29 had been feeding herself after set up, until approximately two weeks ago; however, now

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when staff tried to get her to eat she would only lick at the food on the spoon, or chew and chew.

During a interview with the director of nursing (DON) at on 11/2/17 at 11:09 a.m. she stated that R29 got up and walked to the TV lounge on her own last week. The DON described R29 as having varying levels of alertness.

When interviewed on 11/2/17, at 11:57 a.m. R29's primary physician (MD)-B explained that she does not adjust the antipsychotic medications (used for behaviors and mood) but this decision is made by the geriatric psychiatrist (GP) who orders the medication. MD-B stated staff have not communicated that R29 recently exhibited lethargy symptoms, decrease ability to feed herself and/or decrease in ability to formulate thoughts. MD-B confirmed that further assessment would be conducted.

Review of R19's record revealed the resident had a history of transient ischemic attacks (temporary stroke), repeated falls and had been diagnosed with dementia in 2014. A Brief Interview for Mental Status (BIMS) dated 9/23/17, identified a score of 6/15, indicating severe cognitive impairment. It was noted that R19 experienced drug-induced hallucinations post hip fracture with surgical repair in September of 2017. As a result, an antipsychotic medication, Seroquel 50 milligrams (mg), had been prescribed by the physician for use at bedtime (HS). On 10/3/17, the physician ordered a dose reduction, to titrate from Seroquel 50 mg to 25 mg and then discontinue after 4 days.

Review of R19's nurse's notes from 10/5/17 through 11/2/17, indicated R19 would yell out for help almost every night. The notes indicated R19

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had trouble falling asleep and/or staying asleep throughout the night. Documentation was lacking to indicate staff had assessed the behaviors to determine reasons why R19 called out for help. Documentation showed PRN (as needed) Tylenol (a short acting analgesic medication to treat pain) had been administered to R19 nineteen times throughout the month of October 2017 and that R19 had consistently reported reduced or cessation of pain with the use of the Tylenol.

A nurses' note dated 10/23/17, at 7:19 a.m. indicated R19 had been yelling out, was taken to the bathroom, but had continued yelling. The note indicated R19 had taken off all her clothing and was found lying naked in bed. Staff had transferred R19 to the wheelchair and moved her to the nurse's station where she'd reportedly called staff names and was "messing with everything she could get her hands on."

On 10/24/17, a physician order for Seroquel 25 mg 1 tablet at noon and 1 tablet at night had been prescribed. The rationale documented indicated the resident experienced: agitation, restlessness, yelling and attempts to self-transfer. A nurse's note entered post administration of Seroquel dated 10/25/17, indicated R19 was lethargic and required an EZ stand (mechanical lift) for transfers because R19 was not supporting herself to stand. Nursing notes documentation indicated R19 continued to yell out for help numerous times between 10/25/17 and 11/2/17.

Review of R19's current undated electronic care plan, revealed there were no there were no specific behaviors identified, but nursing staff were to assess and treat pain, identify patterns of behavior, rule out delirium and administer medications as ordered. The care plan also

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indicated nursing assistants were to maintain the safety of the resident, report pain to the nurse, offer conversation, present tasks one at a time, and redirect when restless and no mention of the behaviors to be reported.

Review of the MDS dated 9/23/17, R19 had no physical, verbal or other behaviors of any kind and had no changes in behavior at the time of the assessments.

Observations on 10/31/17, at 12:30 p.m. of R19 indicated she was sitting in her wheelchair in her room, quietly watching her TV. Observation again at 3:30 p.m. revealed R19 was in the hallway outside her room, dressed up for Halloween, smiling and waiting patiently to pass out candy to trick-or-treaters.

Observation on 11/2/17, at 6:39 a.m. indicated R19 was sitting in her wheelchair in her room, asleep. At 6:50 a.m., R19 was awake and now sitting in her wheelchair in the doorway of her room. No behaviors were noted. Later that day at 1:33 p.m., R19 was wheeled by staff to play Bingo, interacting and smiling.

Interview on 11/2/17, at 1:34 p.m. with licensed practical nurse (LPN)-B indicated she felt R19 had not fared well behaviorally without the use of Seroquel once it had been discontinued on 10/3/17. R19 was up at night, trying to transfer herself, sitting in hallways, and was known to be anxious. She was restarted on the Seroquel after the 10/23/17, episode as noted above.

Interview and document review on 11/2/17, at 1:45 p.m. with the RPh-C indicated he agreed according to the nursing documentation, there was no supporting evidence to show

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21535	Continued From page 26 non-pharmacological interventions had been tried prior to initiating R19's antipsychotic Seroquel. The RPh-C stated he felt the root cause of R19's behaviors had been assessed. The RPh-C stated he documented a note just previous to the interview recommending her thyroid laboratory values be checked. He also stated R19 had a complex orthopedic history involving spinal problems that could explain her calling out for help. The RPh-C note dated 11/2/17 revealed the following notations/recommendations: (1)"Seroquel 25 mg BID [twice daily] was restarted on 10/24/17 for agitation, yelling and self transfer attempts. No psychotic or injurious behaviors were reported." (2)"Problems with sleeping reported. Possible pain syndrome present given history. TSH [thyroid stimulating hormone] was low normal when last measured in May." (3)"Non-med interventions not defined before Seroquel restarted." (4)Suggest: (a) Hold the Seroquel due to lack of a documented indication for use. (b)Recheck thyroid labs. (c) Do pain assessment. (d) Document what non-pharmacological interventions were tried before the Seroquel was ordered. The only policy submitted was the October 2014, Pharmaceutical Services Policies and Procedures which indicated the pharmacist was the only person responsible for conducting chart reviews, performance, and monthly drug regimen reviews. There was no mention of how nursing was to implement non-pharmacological interventions prior to initiating the administration of medication, how behaviors were to be monitored, when the	21535		

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physician was to be notified by nursing staff, how the care plan or medications were to be specific for each resident, or how the interdisciplinary team oversaw the care of the residents with behaviors to maintain their highest emotional and psychological well-being.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could audit residents charts for those receiving psychoactive medications and ensure gradual dose reductions or tapers are being attempted in accordance with regulatory guidance. The director of nursing or designee could consult their medical director related to development/revision of policies and procedures related to gradual dose reductions, to ensure primary physicians and mental health practitioners are aware of which party will be responsible to document rationale for attempting or not attempting a gradual dose reduction or dose taper of a psychoactive medication. The director of nursing or designee could report results of audits to the quality assurance committee for follow up to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

21545	MN Rule 4658.1320 A.B.C Medication Errors	21545		12/13/17

A nursing home must ensure that:
A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For

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21545	Continued From page 28 purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21545	corrected	

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review, the facility failed to properly prime the insulin pen prior to administration for 2 of 2 residents (R7, R43) observed and failed to administer a medication according to the physician order for 1 of 1 resident (R43) observed during medication pass. This has the potential to affect any resident who received insulin via an insulin pen.

Findings include:

Observations of medication administration during medication pass were as follows:
(1) On 11/1/17, at 11:57 a.m. registered nurse (RN)-C failed to prime the Novolog insulin pen prior to administering 6 units of insulin to R43.
(2) On 11/1/17, at 12:03 p.m. RN-C failed to prime the Novolog insulin pen prior to administering 7 units of insulin to R7.
(3) On 11/1/17, at 5:41 p.m. licensed practical nurse (LPN)-C failed to prime the Novolog insulin pen prior to administering 7 units of insulin to R7.
(4) On 11/2/17, at 7:21 a.m. LPN-B failed to remove the outer and inner cap on the insulin pen prior to priming the pen and administering 6 units of Novolog to R43.
(5) On 11/2/17, at 8:15 a.m. RN-C administered Protonix (used for acid reflux) to R25 after the resident had finished breakfast. RN-C noted a discrepancy between the medication blister pack label which indicated the medication was to be administered prior to breakfast; however, the medication administration record (eMAR) made no mention of this. RN-C stated "Its not on here [eMAR] so that's ok." and administered the medication without checking the physician's order in the medical record.

Review of R43's medical record indicated medication orders dated 9/25/17, specifically

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noted the medication was to be taken every morning before breakfast.

When interviewed on 11/2/17, at 7:47 a.m. LPN-B indicated she did not realize she needed to uncap the outer and inner needle prior to priming the flex pen. LPN-B was training RN-C and was not aware RN-C had not been priming any insulin pens prior to administration.

Interview on 11/2/17, at 7:58 a.m. with RN-C stated she had not known how to use an insulin pen. She was a new-hire and currently being trained. RN-C explained she had used insulin vials at her previous employment.

Interview on 11/2/17, at 12:34 p.m. with the pharmacist regarding R25's medication administration of Protonix indicated the nurse should have verified the order with the medical record to ensure accuracy. Once the error was noted, the physician should be notified of the error and to clarify if it was acceptable to give the medication after or with meals in the future.

When interviewed on 11/3/17, at 9:53 a.m. the director of nursing indicated she was unaware of the nurses errors with insulin pen preparation prior to administration. She agreed 5 errors of 25 observations placed the facility at a high medication error rate of 20%. The DON indicated the unit coordinator and/or herself input physician orders into the eMAR when the medication is delivered from the pharmacy. The DON confirmed there is no secondary verification step right to ensure accuracy but she agreed this was an area of concern. The DON's expectation is nursing staff needs to verify and clarify orders prior to administration. The DON further indicated all nursing staff needed re-education on insulin

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21545	Continued From page 31 pen preparation and administration. Review of the revised April 2015 Instructions for Use Novolog FlexPen manufacture's insert indicated after attaching the needle to the insulin pen, staff were to pull off the outer needle cap, then the inner needle cap. They were to turn the dose selector to 2 units. Next, they were to hold the FlexPen with the needle pointing upward and tap the cartridge to remove any air bubbles. While keeping the needle pointing upwards, they were to depress the button until the dose selector returned to zero. Once that was performed they could select the number of units needed to be injected into the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing and consultant pharmacist could educate all staff related to medication administration techniques to prevent medication errors and revise facility policies and procedures accordingly. The director of nursing and/or consultant pharmacist could audit medication passes for potential concerns, and report findings to the quality assurance committee for follow up to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21550	MN Rule 4658.1325 Subp. 1 Adminiatration of Medications; Pharmacy Serv. Subpart 1. Pharmacy services. A nursing home must arrange for the provision of pharmacy services.	21550		12/13/17

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to administer medication according to the physician's prescribed order for 2 of 3 residents (R39, R25) reviewed for unnecessary medication.

corrected

Findings include:

R39's quarterly Minimum Data Set (MDS) assessment dated 6/6/17, indicated R39 had short term memory impairment and had a Brief Interview of Mental Status (BIMS) of 4/15-severe cognitive impairment. The MDS also indicated R39 had verbal and physical behaviors 2-6 times during the assessment period. Physician visit note dated 10/3/17, listed diagnoses to include: sexually inappropriate behavior, anxiety, confusion, delusions, insomnia, psychotic disorder and dementia.

During an observation on 11/1/17, from 6:09 p.m. to 6:48 p.m. R39 was outside of the bedroom doorway (near the nurses station) and had stood up 12 times setting off personal alarm in the wheelchair. At 7:03 p.m. R39 is observed to be in his bed calling out to have his "head checked to be sure it was still there".

The social service progress note dated 10/19/17 10:31 a.m. documented the following: It has become clear that the evenings after supper are the most difficult time to manage and redirect his behaviors. This is probably due to a combination of sundowning, medication wearing off and not having as many staff members available...

During review of the psychiatrist progress visit note dated 9/13/17, R39 was to have Seroquel

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changed to 200 milligrams (mg) daily at HS (bedtime) rather than Seroquel 50 mg in the morning (AM) and 100 mg in the evening (HS), for dementia related behavior, agitation and aggression.

Review of the September 2017 medication administration record (MAR) noted the Seroquel dose was adjusted to be administered at bedtime as ordered by the psychiatrist. However, it was noted that on 9/29/17, the administration time that Seroquel was given was changed from the evening to the morning. Documentation was lacking to indicate the psychiatrist had changed the time to the morning.

During interview on 11/3/17, at 9:48 a.m. registered nurse/nurse manager (RN)-A verified the Seroquel had been ordered to be given at bedtime on 9/13/17. RN-A further verified the change or update to the order occurred 9/29/17, during the monthly medication change. RN-A explained the nurse updating the MAR changed/updated the computer order to reflect the directions on the label of the medication card rather than checking the current physician order. RN-A verified the medication was not administered as ordered (HS). She indicated she initiated the medication error process and notified the psychiatrist.

During medical record review the physician order dated 9/25/17, identified R25 should receive 75 micrograms (mcg) of levothyroxine, a medication used to treat low thyroid, every morning on an empty stomach, 30-60 minutes before breakfast. Review of the eMar indicated the order had been changed to "Give at PM per daughter-in-law. She says this is how she wants [R25] to continue to take this, in case she returns home." There was

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21550	Continued From page 34 no indication the physician had been consulted to determine whether the change in time was acceptable. Interview on 11/2/17, at 12:34 p.m. with the registered consulting pharmacist (RPh-C) confirmed that once an error related to administration time is identified, the physician should be notified to clarify whether the medication should be administered different from the order. Interview on 11/3/17, at 9:53 a.m. the DON indicated it was the expectation that staff clarify physician orders prior to administration of medications and that discrepancies should be discussed and reported with the physician. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could audit medication orders to ensure proper transcription onto medication sheets and pharmacy labels. The director of nursing could educate staff on proper technique for administration of insulin utilizing insulin pens, and audit staff technique to ensure injectable medications are being administered in accordance with manufacturer's guidelines. The director of nursing or designee could report findings of audits to the quality assurance committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21550		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may	21565		12/13/17

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self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure the physician participated as part of the interdisciplinary team to determine whether self-administration of medications was appropriate for 1 of 1 resident (R27) reviewed who self-administered medications and had a history of medication noncompliance.

corrected

Findings include:

R27's most recent annual Minimum Data Set (MDS) assessment dated 9/22/17, indicated no symptoms of depression and the Brief Interview for Mental Status (BIMS) score of 15/15, intact cognition. The MDS further identified R27's behavioral symptoms had improved since the previous assessment. A Care Area Assessment (CAA) did not trigger for mood, psychosocial nor behavioral concerns.

R27's psychoactive medication CAA dated 10/7/16, indicated R27 used antidepressant (AD) medications.

The MDS face sheet dated 11/3/17, indicated diagnoses of unspecified affective mood disorder, delusional disorders, personality disorder and anxiety disorder.

The guardianship papers from Watonwan County, dated 12/28/16, indicated R27 had been

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21565	Continued From page 36 diagnosed with severe bipolar disease and paranoia; and also needed assistance in making decisions with respect to medical, nutritional and hygienic needs. R27's care plan did not identify whether R27 did or did not have the capability to self-administer medications. A Limited Evaluation progress note, dated 6/1/17 by R27's family nurse practitioner (FNP) indicated R27 was hospitalized in 4/17 for refusing medications, and had a history of dementia and paranoia. R27's Physician Orders, dated 11/3/17 included amlodipine besylate (a cardiovascular agent), hydralazine (an antihypertensive), and warfarin sodium (a blood-thinner). R27's Medication Administration Sheets, dated 11/3/17 indicated R27 could self-administer her medications after set-up. The start date of the order to self-administer was dated 11/2/17. During observation and interview on 11/1/17, at 6:21 p.m. R27 was noted to have a brown-colored pill which she stated was warfarin and the white pill located in the medication cup, was for blood pressure. The medication cup was located on the overbed table in R27's room. R27 explained the nurse left the medications with her and that she would take them later. During interview on 11/3/17, at 9:01 a.m. R27 was seated in her recliner, making flowers out of empty medication cups she had stored on the window sill. R27 stated staff were now observing her while she finished taking her medications. She indicated this was a new/recent occurrence	21565		

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within the last couple of days.

When interviewed on 11/3/17, at 9:07 a.m. R27's geriatric psychiatrist (GP) stated she did not think R27 should be left alone without supervision with prescribed medications due to R27's hoarding behaviors and medication noncompliance history; stating, "I am glad you brought that up."

During interview on 11/3/17, at 10:29 a.m. RN-D stated she had not noticed that R27 would hoard medications and felt R27 would be capable to take pills on her own in her room. RN-D confirmed R27's physician had not been consulted as part of the interdisciplinary assessment; however, a fax had just been sent this week to obtain an order. RN-D reported that R27 was "very intelligent," and did sometimes refuse medications.

During interview on 11/3/17, at 12:42 a.m. the director of nursing (DON) stated the facility lacked policies and procedures related to self-administration of medication, and it was something they were "working on."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could update facility procedures to ensure physicians are included in the interdisciplinary assessment of self-administration of medications, and audit resident records to ensure that a physician's order is in file for those choosing to self-administer. The director of nursing could review and revise policies and procedures related to self-administration of medication, and educate staff on those changes. The director of nursing or designee could report findings of audits to the quality assurance committee for follow up to ensure ongoing compliance.

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21565	Continued From page 38 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		12/13/17

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21800	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation and interview , the facility failed to ensure the updated Combined Federal and Minnesota State Bill of Rights information was posted within the facility. This had the potential to affect all 45 residents who resided in the facility and all visitors who visited the facility. Findings include: During the initial tour of the facility on 10/31/17, at 8:22 a.m., the combined Federal and Minnesota State Bill of Rights (BOR) information was posted in the hallway and had a date of 07/07. Further examination of the BOR noted the number for the regional ombudsman was not filled in. Review of a facsimile documentation received from the facility on 11/6/17, at 3 p.m. verified the updated 2016 resident BOR was not posted within the facility and an updated poster version has been ordered. SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate staff on policies and procedures to ensure residents/families/visitors have updated rights and a receipt of them receiving the rights is kept. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21800	corrected	
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights	21805		12/13/17

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21805	Continued From page 40 Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R27) reviewed for dignified services was treated with respect and dignity related to management of her hoarding behaviors, and retention of her personal property items. Findings include: During observation and interview with R27 on 10/31/17 at 11:01 a.m., R27 stated she was upset about not being allowed to keep personal belongings in her room. R27 stated limitations to access to her personal belongings had started in April of this year, and that she'd been asked to sign a contract during a care conference with her daughters' present to allow her room to be searched and items removed to prevent clutter. During the interview, R27 was able to appropriately express her concerns. R27's room was observed during the 11:01 a.m. 10/31/17 observation, to be a private unit with three wind chimes hanging from a ceiling fan with butterflies on them. There were a few personal items observed on the window sill and she had a recliner and a butterfly shaped scarf holder observed on the wall behind her recliner. The remainder of the walls were bare. Two dressers were observed in place along the sides of a wall, otherwise that half of the room was empty. There	21805	corrected	

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was no bed in the room and R27 stated she routinely slept in her recliner.

During continued observation and interview on 11/1/17, at 6:21 p.m. R27 stated she did not feel her rights and feelings were respected at the facility related to respect for her and her belongings, "There is a poster on the wall when you come in that talks about respect, but it doesn't happen." R27 displayed a flat facial affect, and paused frequently when speaking, sighing and looking down at her lap. R27 stated she felt "bullied" by social worker (SW)-A and that SW-A "assumes things she shouldn't and issues a lot of directives."

When interviewed on 11/2/17, at 10:20 a.m. SW-A stated due to her clinical social work license, she had originally been providing care for R27 when she first came. SW-A further stated the resident's hoarding behaviors were very, very bad and her room used to be a "huge mess." SW-A acknowledged R27 felt "singled out," by the room contract and was upset about her room being searched.

Social Service progress notes included feedback from April 2017 when SW-A had spoken with R27's daughters
regarding what to do with the resident's room situation. SW-A had documented that [R27's] hoarding behaviors had increased over the past few months, and her room was cluttered with a large amount of papers and personal items, including food and food containers she refused to throw away. SW-A had documented 4/19/17, "Upon [R27's] anticipated return to [facility name] she will need to sign off on a room agreement that will specifically state what she is allowed or not allowed to keep in her room." Additional

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documentation from 4/24/17 verified staff had sorted through the resident's belongings while the resident was hospitalized. The note indicated junk mail, garbage, food, etc had been thrown away, and R27's personal items were sorted, organized or sent home with the resident's daughters. In addition, arrangements were made for R27 to move to a new room upon her hospital return.

Additional social service progress included: 5/20/17: [R27] "has been back at [facility] for a little over a week. She has been following her room and medication agreements for the most part....Her mood has been up and down and she continues to get preoccupied with certain items that are 'missing'." 6/26/17: [R27] "was angry and tearful when her belongings were searched and stated she never signed off on the agreement to these room searches, was reminded her guardians had signed off on this procedure." 7/6/17: "Room check completed 7/6/17, ...Several straws, cookies, rice Krispies, jellies, applesauce and one empty cup were removed. [R27] was upset, stating she needed the items in her bag in case she got sent 'somewhere'. "

R27's licensed mental health provider (LMHP) was unavailable for interview on 11/3/17, when attempts were made to contact him by phone. On 11/8/17, at 8:46 a.m., the LMHP was able to return the call and stated he had seen R27 approximately 27 or so times in the facility over many months. The LMHP stated he felt sorting R27's belongings while she was not in the room could increase her level of paranoia.

The Minnesota State Combined Federal and State Bill of Rights, revised 11/28/16 includes: The resident has a right to a dignified existence, self-determination, and communication with and

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21805	Continued From page 43 access to persons and services inside and outside the facility: 1. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must promote and protect the rights of the resident. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		