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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6QVR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**
2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/11/2013** (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 **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sandra Christle, HFE NE II 02/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/07/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/19/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN - 24-5387

An extended NOTC survey was completed on August 19, 2013 and deficiencies were found, the most serious at a scope and severity level of J. Conditions in the facility constituted IJ (F323) and SQC (F226 & F323).

As a result, we imposed State Monitoring effective September 16, 2013. In addition, we recommended the following remedy to the CMS RO for imposition:

Civil Money Penalties effective August 19, 2013; CMS imposed the following:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013
- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC

On November 8, 2013 we conducted a health PCR and on November 21, 2013, Public Safety conducted a LSC PCR. All LSC deficiencies were corrected. But Health had three deficiencies uncorrected. The most serious health deficiency was at a S/S level of E. As a result of the most recent revisit, State monitoring will remain in effect. In addition, we recommended the following remedies to the CMS RO for imposition and CMS concurred:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013, remain in effect
- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013, remain in effect
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013, remain in effect

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC

A second Health PCR was completed on December 10, 2013. All of the deficiencies were found corrected and the facility was in substantial compliance effective December 10, 2013. As a result of the second PCR we recommended the following remedies to the CMS RO and CMS concurred:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013, will remain in effect
- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013, will remain in effect
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013, be discontinued December 10, 2013.

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC.

See attached CMS-2567B forms from this revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5387 February 7, 2014

Mr. David Uselman, Administrator
St. Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

Dear Mr. Uselman:

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 10, 2013 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 3, 2014

Mr. David Uselman, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387022

Dear Mr. Uselman:

On September 12, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 16, 2013. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013. (42 CFR 488.417 (b))

On November 21, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty of $4,200.00 per instance for the instance of noncompliance at F323 (S/S: J) identified in the CMS-2567 survey ending August 19, 2013

- Federal Civil Money Penalty of $1,500.00 per instance for the instance of noncompliance at F314 (S/S: G) identified in the CMS-2567 survey ending August 19, 2013

Also, the CMS Region V Office notified you in their letter of November 21, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2013.

This was based on the deficiencies cited by this Department for an extended survey completed on August 19, 2013 and not obtaining substantial compliance at the Post Certification Revisit (PCR) completed on November 8, 2013. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required

On November 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 21, 2013, 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 an extended survey, completed on August 19, 2013.

We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2013. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on August 19, 2013. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, this Department recommended and CMS concurred with our recommendations and authorized us to notify you of the actions related to the imposed remedies:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of $4,200.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of $1,500.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013 will remain in effect. (42 CFR 488.417 (b))

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2013.

On December 10, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 25, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 8, 2013, effective December 10, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 10, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of November 21, 2013:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of $4,200.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of $1,500.00 will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013 be discontinued, effective December 10, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of September 12, 2013 and CMS notified you in their letter of November 21, 2013 in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2013.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5387r3_13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	12/10/2013

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	12/10/2013	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	12/10/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	12/10/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM /SC	2/3/2014		12/10/13
CMS RO				

Followup to Survey Completed on: 8/19/2013

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

AH Form Approved
2/25/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00260	A. Building B. Wing	12/10/2013

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. · LSC	Correction Completed 12/10/2013	ID Prefix 20895 Reg. # MN Rule 4658.0525 Subp. : LSC	Correction Completed 12/10/2013	ID Prefix 21620 Reg. # MN Rule 4658.1345 LSC	Correction Completed 12/10/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/SC	Date: 2/3/2014	Signature of Surveyor:	Date: 12/10/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/19/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6QVR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**

2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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 **11/21/2013** (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 **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Eva Loch, HFE NE II — 11/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 02/07/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/19/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN - 24-5387

An extended NOTC survey was completed on August 19, 2013 and deficiencies were found, the most serious at a scope and severity level of J. Conditions in the facility constituted IJ (F323) and SQC (F226 & F323).

As a result, we imposed State Monitoring effective September 16, 2013. In addition, we recommended the following remedy to the CMS RO for imposition:

Civil Money Penalties effective August 19, 2013; CMS imposed the following:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013
- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC

On November 8, 2013 we conducted a health PCR and on November 21, 2013, Public Safety conducted a LSC PCR. All LSC deficiencies were corrected. But Health had three deficiencies uncorrected. The most serious health deficiency was at a S/S level of E. As a result of the most recent revisit, State monitoring will remain in effect. In addition, we recommended the following remedies to the CMS RO for imposition and CMS concurred:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013, remain in effect
- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013, remain in effect
- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013, remain in effect

The facility is subject to a loss of NATCEP for two years beginning August 19, 2013 due to the extended survey which identified SQC.

See attached CMS-2567 and CMS-2567B from these revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1680 0002 2928 2130

November 1, 2013

Mr. David Uselman, Administrator
St. Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387022, H5387075 and H5387058

Dear Mr. Uselman:

On September 12, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on August 19, 2013 that included an investigation of complaint number H5387057 and H5387058. Conditions in the facility constituted both substandard quality of care and an immediate jeopardy to resident health or safety. This survey found the most serious deficiencies to be isolated deficiencies that constituted immediate Jeopardy (Level J), whereby corrections were required.

However, compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the August 19, 2013 extended survey have not yet been verified. The most serious health LSC deficiencies in your facility at the time of the standard extended survey were found to isolated deficiencies that constituted immediate Jeopardy (Level J), whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 19, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 19, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 19, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been

subject to a an extended survey. Therefore, St Olaf Residence is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 19, 2013. This prohibition is not subject to appeal. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

A copy of the Post Certification Revisit Form (CMS-2567B) from the August 19, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

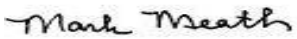
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 538770dayNotice.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	R 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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 A post certification revisit was conducted by the Minnesota Department of Health on November 4 through November 8, 2013. During the course of the survey an H complaint was investigated (H 5387061) and was not substantiated.	{F 000}	**F 280** 1. Corrective Action: A) The care plan of resident #18 was updated to reflect that the correct splinting requirements and the potential for contractures related to CVA were present. Therapy evaluated for baseline measurements to upper and lower extremities. The care sheet was reviewed and revised to reflect the resident's current needs related to splinting. Restorative nursing will pick up ROM to all extremities upon completion of therapy. 2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by the same deficient practice. B) The care plans of all residents with contractures or at risk were reviewed and revised to reflect their current needs including measures to prevent worsening or increased tone. C) Nursing staff was educated on the importance of following care sheets and care plans in relationship to splinting and	
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise a plan of care for the left hand to prevent further decline for 1 of 3	{F 280}	Accepted 12-10-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 12/6/13

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

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{F 280}	Continued From page 1 residents (R18) reviewed for range of motion (ROM). Findings include: R18 left hand splint was not implemented as the splint went missing. R18 was observed on 11/6/13, at 9:05 a.m. to be dressed and sitting in a wheelchair in the room. R18 was noted to have left sided paralysis from a previous stroke. R18's left arm was noted to be flaccid and her hand was curved inward at the wrist. The nursing assistant (NA)-A was applying a left lower extremity leg brace. R18 explained she gets exercises for her legs twice daily in her room. When interviewed R18 was asked if she had a splint device for her left upper extremity. R18 said she did not know what happened to the left hand splint as it went missing a long time ago. R18 thought it may have been in a box of belongings that went in storage some time ago. R18 said that she thought her left wrist was worse, contracting in towards her body. She noted mild pain in the left wrist mostly at night. The medical orders dated August 2013 included: To wear right hand splint on at bedtime, off in morning. The medical orders dated 11/6/13 (day of survey) were to discontinue orders for right hand splint-not needed. The current care plan dated 9/13/13, was reviewed and included potential for increased contractures to hand related to CVA (stroke) left side. Goal was to decrease risk of contractures. Interventions were to apply splint as ordered. Care plan also included need for total assist with bathing and assist of one with all other grooming	{F 280}	RECEIVED DEC - 9 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION ~~ensuring appropriate orders in~~ place and/or available. D) All residents will be reviewed for any changes in care at care conferences including increased need for ADL's and use of assistive devices. 3. Date of Completion: 11/25/2013 4. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. The Correction will be Monitored by: Director of Nursing or designee	

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{F 280}	Continued From page 2 tasks. The care plan did not have any interventions identified for the left hand to prevent contracture. The restorative care plan dated Sept. through Dec. 2013 listed potential for increase contractures to hand related to stroke, left side. Intervention listed was splint as ordered. The current medication administration record dated November 2013 included: wear right hand splint, on at bedtime, off in morning. The October 2013 treatment administration record contained initials of staff as having completed the application of and removal of a left hand splint. The director of nursing (DON) confirmed that was inaccurate documentation as the resident did not have a hand splint. The first floor restorative ambulation and range of motion program book was reviewed for October 2013. R18 had orders for and received daily exercises to both lower legs. NA-A was interviewed on 11/6/13, at 9:10 a.m. and explained he had not seen a hand splint for R18. When asked if to see the current nursing assistant assignment sheet, NA-A showed the surveyor that there was direction on the task sheet to apply a right hand splint for R18. The first floor resident care coordinator (RN)-A was interviewed on 11/6/13, at 9:22 a.m. and said, "I am fairly new here; I will have to look into this." The DON was interviewed on 11/6/13, at 10:20 a.m. and stated R18 has never had a left hand splint. The DON did say that R18 previously had	{F 280}		

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{F 280}	Continued From page 3 a right hand splint but it interfered with R18's ability to smoke. The DON was asked why a splint would be needed on R18's right hand if the resident had left sided hemiparesis and the DON confirmed there was no indication for use of a right hand splint and that was most likely an error. The DON added that after R18's latest return from hospital she had no left hand splint. The DON said, "I am curious to know how long it's been missing." The DON also stated she should have had that implemented a year and a half ago. The DON obtained orders for Occupational Therapy to evaluate R18's left wrist contracture. The DON also stated that R18 was included in the internal audit for range of motion but somehow the left hand contracture and treatment for it was missed. On 11/6/13 at 11:25 a.m. the COTA measured 35 degrees of flexion to the left wrist and recommended a restorative program to prevent left wrist and finger contractures. The COTA asked R18, "Would you wear a splint?" R18 replied, "Yes." The COTA was able to get the left wrist to full range with stretching and stated R18 would benefit from a restorative program and recommended a hand splint and range of motion exercises. The COTA said the therapy department will evaluate and treat the left wrist contracture. The COTA stated that there were no previous measurements of the left upper extremity in the records at the facility. The facility policy titled, Restorative Nursing Program, dated as revised October 2013, indicated that it was the facilities policy to promote each resident's ability to attain maximum functional potential. Restorative nursing includes, but is not limited to skill practice in walking,	{F 280}		

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{F 280}	Continued From page 4 dressing, grooming, eating, swallowing, transferring, amputation care, splint care, communication, passive range of motion/active range of motion (PROM/AROM), and bed mobility.	{F 280}		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a splint device was implemented to prevent further decline for 1 of 3 residents (R18) reviewed for range of motion (ROM). Findings include: R18 left hand splint was not implemented as the splint went missing. R18 was observed on 11/6/13, at 9:05 a.m. to be dressed and sitting in a wheelchair in the room. R18 was noted to have left sided paralysis from a previous stroke. R18's left arm was noted to be flaccid and her hand was curved inward at the wrist. The nursing assistant (NA)-A was applying a left lower extremity leg brace. R18 explained she gets exercises for her legs twice daily in her	{F 318}	**F318** 1. Corrective Action: A) Resident #18 has been reassessed for splinting needs. She was assessed for a ROM program to prevent ULE and LLE contractures and care plan reflects current needs. 2. Corrective Action as is applies to others: A) All residents in need of splints/braces, ROM, and ambulation have the potential to be affected by these deficient practices. B) The Restorative Nursing Policy was reviewed and Nursing Staff members were	

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{F 318}	Continued From page 5 room. When interviewed R18 was asked if she had a splint device for her left upper extremity. R18 said she did not know what happened to the left hand splint as it went missing a long time ago. R18 thought it may have been in a box of belongings that went in storage some time ago. R18 said that she thought her left wrist was worse, contracting in towards her body. She noted mild pain in the left wrist mostly at night. The medical orders dated August 2013 included: To wear right hand splint on at bedtime, off in morning. The medical orders dated 11/6/13 (day of survey) were to discontinue orders for right hand splint-not needed. The current care plan dated 9/13/13, was reviewed and included potential for increased contractures to hand related to CVA (stroke) left side. Goal was to decrease risk of contractures. Interventions were to apply splint as ordered. Care plan also included need for total assist with bathing and assist of one with all other grooming tasks. The restorative care plan dated Sept. through Dec. 2013 listed potential for increase contractures to hand related to stroke, left side. Intervention listed was splint as ordered. The current medication administration record dated November 2013 included: wear right hand splint, on at bedtime, off in morning. The October 2013 treatment administration record contained initials of staff as having completed the application of and removal of a left hand splint. The director of nursing (DON) confirmed that was inaccurate documentation as the resident did not have a hand splint.	{F 318}	educated on the need to complete the programs as ordered and document routinely. 3. Date of Completion: 11/25/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. Corrections will be monitored by: Director of Nursing or Designee	

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{F 318}	Continued From page 6 The first floor restorative ambulation and range of motion program book was reviewed for October 2013. R18 had orders for and received daily exercises to both lower legs. NA-A was interviewed on 11/6/13, at 9:10 a.m. and explained he had not seen a hand splint for R18. When asked if to see the current nursing assistant assignment sheet, NA-A showed the surveyor that there was direction on the task sheet to apply a right hand splint for R18. The first floor resident care coordinator (RN)-A was interviewed on 11/6/13, at 9:22 a.m. and said, "I am fairly new here; I will have to look into this." The certified occupational therapist (COTA) was interviewed on 11/6/13, at 9:30 a.m. looked into the issue and replied that the surveyor would have to talk to the DON. The DON was interviewed on 11/6/13, at 10:20 a.m. and stated R18 has never had a left hand splint. The DON did say that R18 previously had a right hand splint but it interfered with R18's ability to smoke. The DON was asked why a splint would be needed on R18's right hand if the resident had left sided hemiparesis and the DON confirmed there was no indication for use of a right hand splint and that was most likely an error. The DON added that after R18's latest return from hospital she had no left hand splint. The DON said, "I am curious to know how long it's been missing." The DON also stated she should have had that implemented a year and a half ago. The DON obtained orders for Occupational Therapy to evaluate R18's left wrist contracture.	{F 318}		

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{F 318}	Continued From page 7 The DON also stated that R18 was included in the internal audit for range of motion but somehow the left hand contracture and treatment for it was missed. On 11/6/13 at 11:25 a.m. the COTA measured 35 degrees of flexion to the left wrist and recommended a restorative program to prevent left wrist and finger contractures. The COTA asked R18, "Would you wear a splint?" R18 replied, "Yes." The COTA was able to get the left wrist to full range with stretching and stated R18 would benefit from a restorative program and recommended a hand splint and range of motion exercises. The COTA said the therapy department will evaluate and treat the left wrist contracture. The COTA stated that there were no previous measurements of the left upper extremity in the records at the facility. The facility policy titled, Restorative Nursing Program, dated as revised October 2013, indicated that it was the facilities policy to promote each resident's ability to attain maximum functional potential. Restorative nursing includes, but was not limited to skill practice in walking, dressing, grooming, eating, swallowing, transferring, amputation care, splint care, communication, passive range of motion/active range of motion (PROM/AROM), and bed mobility.	{F 318}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	{F 431}		

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{F 431}	Continued From page 8 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications with shortened use dates were properly dated after opening potentially affecting 5 of 13 residents (R123, R124, R37, R57, R72) who received insulin for diabetes. In addition an expired Tubersol (used to test for tuberculosis)	{F 431}	**F431** 1. Corrective Action: A) The insulin pens have been discarded. All new pens are labeled. New pharmacy started on 12/1/13 and standard practice to also label all pens with a sticker to remind staff to label once taken out of the box. B) The tuberculin vial was discarded. The fridges are monitored nightly for compliance. 2. Corrective actions as it applies to other residents: A) All future residents and future staff members have the	

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{F 431}	Continued From page 9 vial was not removed from the medication storage area, potentially affecting newly admitted residents and new employees. Findings include: The facility's medication storage system was observed on the third floor on 11/4/13, at 9:25 a.m. in the presence of the licensed practical nurse (LPN)-A. A Lantus insulin pen was in use for R123, but was undated as to when it was opened, and had a pharmacy delivery date of 10/26/13. A Lantus insulin (used to treat diabetes) pen and a Novolog (used to treat diabetes) insulin pen were in use for R124, but were not dated as to when they were opened, and both had a pharmacy delivery date of 10/25/13. There was a Tubersol vial in the refrigerator with opened dated 9/27/13, the LPN-A stated the Tubersol "expired a week ago". When interviewed LPN-A stated the Lantus and Novolog insulin "were good for 28 days" and they should have been dated when opened. The second floor medication carts were inspected on 11/4/13, at 9:37 a.m. p.m. in the presence of the licensed practical nurse (LPN)-B. A Novolog insulin pen was in use for R37, with a pharmacy delivery date of 7/2/13, which was again unlabeled with the open date. A Humulin (used to treat diabetes) insulin pen in use for R57, with a pharmacy delivery date of 9/3/13, labeled open date 9/3/13, had expired and was not removed from the medication storage area. There was a Lantus insulin pen in use for R72, with a pharmacy delivery date of 7/9/13, which was also undated when opened. The LPN-B confirmed insulin pens used for R37 and R72 were undated, and explained that every insulin pen and vial	{F 431}	potential to be affected by the same deficient practice. B) Nursing staff was educated on the need to date all meds when opened and to discard after 30 days. 3. Completion date: 11/25/13 4. Recurrence will be prevented by: A) Random audits will be conducted weekly x4 then monthly x3 with findings presented to the QA committee for follow up/discussion. 5. Completion will be monitored by: Director of Nursing or Designee	

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{F 431}	Continued From page 10	{F 431}		

needed to be dated when first used to determine the expiration date, since they were good for 28 days after opening. The LPN-B also verified R57's Humulin expired, and explained the Humulin was discontinued, however was not removed from the medication cart.

During interview on 11/5/13, at 9:43 a.m. the director of nursing (DON) stated the staff were trained and were expected to write the date on the insulin pens when they were initially used. The DON also explained, staff received training on October 4th about regarding proper medication labeling, medication storage. The DON also stated the facility was in process to change pharmacy.

The consultant pharmacist (CP) was called on 11/5/13, at 10:30 a.m., and was not available for interview.

The manufacturer's recommendation in the Lantus package insert indicated in-use/opened insulin had to be discarded after 28 days. The Novolog package insert for storage indicated open vials and opened Novolog flex pen were to be kept at room temperature "for up to 28 days."

The undated Medications to Date When Opened policy indicated the Novolog, and Lantus cartridge or pen was good for "28 days" after its first use, and the Humulin cartridge or pen was good for "30 days" after its first use.

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00260	A. Building B. Wing	11/8/2013

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20255** Reg. # **MN Rule 4658.0070** LSC	Correction Completed **10/03/2013**	ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **10/03/2013**	ID Prefix **20335** Reg. # **MN Rule 4658.0130** LSC	Correction Completed **10/03/2013**
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **10/03/2013**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **10/03/2013**	ID Prefix **20625** Reg. # **MN Rule 4658.0450 Subp. 1 A-I** LSC	Correction Completed **10/03/2013**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **10/03/2013**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **10/03/2013**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	Correction Completed **10/03/2013**
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **10/03/2013**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp. 6 B** LSC	Correction Completed **10/03/2013**	ID Prefix **20940** Reg. # **MN Rule 4658.0525 Subp. 9** LSC	Correction Completed **10/03/2013**
ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp. 2** LSC	Correction Completed **10/03/2013**	ID Prefix **21290** Reg. # **MN Rule 4658.0710 Subp. 3 A** LSC	Correction Completed **10/03/2013**	ID Prefix **21325** Reg. # **MN Rule 4658.0725 Subp. 1** LSC	Correction Completed **10/03/2013**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GD	11/26/2013	30182	11/08/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00260	A. Building B. Wing	11/8/2013

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21475** Reg. # **MN Rule 4658.1005 Subp. 1** LSC	Correction Completed **10/03/2013**	ID Prefix **21525** Reg. # **MN Rule 4658.1305 A.B.C** LSC	Correction Completed **10/03/2013**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **10/03/2013**
ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 AB(** LSC	Correction Completed **10/03/2013**	ID Prefix **21545** Reg. # **MN Rule 4658.1320 A.B.C** LSC	Correction Completed **10/03/2013**	ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp. 4** LSC	Correction Completed **10/03/2013**
ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **10/03/2013**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp. 2** LSC	Correction Completed **10/03/2013**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **10/03/2013**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	Correction Completed **10/03/2013**	ID Prefix **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	Correction Completed **10/03/2013**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	Correction Completed **10/03/2013**
ID Prefix **22060** Reg. # **MN Rule 4658.4005** LSC	Correction Completed **10/03/2013**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/G	11/26/2013	30182	11/08/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/19/2013			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	11/8/2013

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **10/03/2013**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **10/03/2013**
ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/03/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/03/2013**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/03/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/03/2013**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GD	11/26/2013	30182	11/08/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	11/8/2013

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0327** Reg. # **483.25(j)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/03/2013**
ID Prefix **F0387** Reg. # **483.40(c)(1)-(2)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **10/03/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **10/03/2013**
ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **10/03/2013**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **10/03/2013**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GD	11/26/2013	30182	11/08/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/19/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing 01 - MAIN BUILDING 01	11/21/2013

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0027	08/23/2013	ID Prefix Reg. # NFPA 101 LSC K0029	10/08/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 11/26/2013	Signature of Surveyor: 28120	Date: 11/21/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/13/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2304 1219

November 27, 2013

Mr. David Uselman, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387022 and H5387061

Dear Mr. Uselman:

On September 12, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 16, 2013. (42 CFR 488.422)

On November 1, 2013, this Department recommended and the Centers for Medicare and Medicaid Services (CMS) concurred and informed you in their letter of November 21, 2013 that the following enforcement remedies were being imposed:

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of $4,200.00. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of $1,500.00. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of November 21, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2013.

This was based on the deficiencies cited by this Department for an extended survey completed on August 19, 2013 that included an investigation of complaint number H5387075 and H5387058. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On November 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 21, 2013 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 an extended survey, completed on August 19, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 8, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on November 8, 2013. The deficiencies not corrected are as follows:

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0318 -- S/S: D -- 483.25(e)(2) -- Increase/prevent Decrease In Range Of Motion
F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

- Per instance civil money penalty of $4,200.00 for the deficiency cited at F323, effective August 19, 2013, for a total penalty of $4,200.00 would remain in effect. (42 CFR 488.430 through 488.444)

- Per instance civil money penalty of $1,500.00 for the deficiency cited at F314, effective August 19, 2013, for a total penalty of $1,500.00 would remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 19, 2013 would remain in effect. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

As we notified you in our letter of September 12, 2013 and CMS notified you in their letter of November 21, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 19, 2013.

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

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

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (6521) 201-3790

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6QVR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**

2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/19/2013** (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 **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 11/12/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 11/19/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/19/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

At the time of the extended survey completed August 19, 2013, two complaint investigations were completed, H5387057 and H538705, and substantiated during this period. Deficiencies were issued as a result of substantiated findings at F323, also the facility was not in substantial compliance with the participation requirements. Conditions in the facility constituted both substandard quality of care (SQC) and immediate jeopardy (IJ) to resident health or safety. The facility would not be given an opportunity to correct before remedies are imposed. As a result, this department imposed state monitoring effective September 16th. In addition, we recommended to the CMS Region V Office that the following remedy be imposed:

- CIVIL MONEY PENALTY

Refer to the following forms: CMS 2567 for both Health and Life Safety Code, including the facility's plan of correction. Post certification revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5779

September 11, 2013

Mr. David Uselman, Administrator
St. Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387022, H5387057 and H5387058

Dear Mr. Uselman:

On August 19, 2013, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 19, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number H5387057 and H5387058.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 19, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number H5387057 and H5387058 that was found to be substantiated.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on August 16, 2013, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective September 16, 2013. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil Money Penalty (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Olaf Residence is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 19, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

Failure to submit an acceptable PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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

If substantial compliance with the regulations is not verified by November 19, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 19, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 09/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING ______ B. WING ______	C 08/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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 A recertification survey was conducted by the Minnesota Department of Health on August 12 through August 19, 2013. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to a resident's elopement which resulted in the high potential for harm or death. The IJ began August 14, 2013, at 6:23 p.m. The IJ was removed on August 16, 2013, at 2:25 p.m. THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. During the course of the survey two of two H complaints were substantiated. H5387057 was substantiated at F315 and H5387058 was substantiated at F241.	F 000	**F 157** 1. Corrective Action: A) The physician of Resident #68 was notified of his medication refusals, some medications were discontinued. B) The physician was notified that Ativan and Ambien were not given to Resident #81 on said dates and since has been administered timely. C) The physician of Resident #18 was notified of the swelling and bruising of the resident's leg and the family was updated with new orders 2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by this deficient practice. B) The Change of Condition Policy was reviewed and Nursing Staff were educated on the policy. C) Pharmacy was contacted by the DON and a plan was put	OK [signature]
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in	F 157		

accepted [signature] 10-28-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 9/24/13

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

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F 157	Continued From page 1 injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure significant changes in condition were reported to the physician for 1 of 1 resident (R68) who received dialysis services; for 1 of 8 residents (R81) whose physician was not notified when a medication was not available and the resident exhibited increased symptoms; and for 1 of 1 resident (R18) who developed cellulitis on the leg.	F 157	in place to receive medications in a timely manner. The facility will now receive two delivery runs daily and new orders within 2 hour time frame any issues are immediately reported to the DON. D) Nursing Staff was educated on the need to contact pharmacy if medications are not received on the expected run. A direct access number has been given in case poor pharmacy response. E) Nursing Staff was educated on the contents of the Pyxxis machine and that they are to use the Pyxxis machine to obtain medications when they are not available from pharmacy. 3. Date of Completion: 10/3/2013 4. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning.	

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F 157	Continued From page 2 Findings include: R68 consistently did not receive two of his medication and his physician was not notified of the refusals. A significant change Minimum Data Set (MDS) was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. He needed extensive assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene. He received dialysis and received a therapeutic diet as result of that. R68's physician ordered the resident receive Kionex 15 grams/60 milliliter (ml) suspension orally daily to treat hyperkalemia (elevated potassium) on 6/27/13. A review of the Medication Administration Records (MAR) for June 2013, July 2013, and August 2013, revealed the resident had not received the medication on all but two occasions. The documentation on the MAR document indicated the resident refused the medications. A review of the medical record revealed no documentation of the resident's physician being informed of the resident's refusal. R68's physician ordered the resident receive Viactiv chewable tablets orally on a daily basis for osteoporosis on 6/12/13. A review of the MAR for June 2013, July 2013, and August 2013, revealed	F 157	5. The Correction will be Monitored by: A) Director of Nursing or designee RECEIVED SEP 26 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 157	Continued From page 3 the resident had not received the medication on all but two occasions. The documentation on the MAR document indicated the resident refused the medications. A review of the medical record revealed no documentation of the resident's physician being informed of the resident's refusal. An interview with R68 was completed on 8/16/13, at 2:15 p.m. and he reported he had not refused to take any of his medications. An interview with licensed practical nurse (LPN)-D was completed on 8/16/13, at 9:30 a.m. LPN-D reported the resident consistently refused these medications and was unsure if the physician had been made aware of the resident's refusal. She reported they had been told just to document the resident's refusal on the back of the MAR. An interview with the director of nurses (DON) was conducted on 8/19/13, at 12:16 p.m. She verified the findings. The undated Resident Change of Condition Physician Notification policy directed staff to notify the attending physician or physician on call of changes in resident's condition or health status. The policy did not specifically direct staff to notifiy the physician of resident's refusal to take medications. R81's primary physician was not notfied when the resident did not reveive anti-anxiety medication from 8/2/13 through 8/5/13, or the hypnotic medication Ambien from 6/17/13 through 6/26/13 according to physician orders. Nurse's notes dated 6/17/13 through 8/5/13, at no	F 157		

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F 157	Continued From page 4 point was the physician notified of medications not being available and given as ordered for R81. On 8/5/13, at 1:40 p.m. a Nurse's Note indicated R81 was noted to have "increased tremors, sweating, droopy, had ate very little at breakfast, no lunch, had bad breath." According to the note, the pharmacy had been called regarding Ativan and writer wrote had spoken with someone that medication had been sent out. The nursing note on 8/5/13, did not state the physician was notified of R81's noted change of status. R81's quarterly MDS dated 7/8/13, indicated R81 had anxiety disorder, delusions, manic depression and psychotic disorder (other than schizophrenia). The MDS also indicated R81 was taking antipsychotic, antianxiety, antidepressant and hypnotic medications. R81's Cognitive loss/dementia Care Area Assessment (CAAs) dated 10/8/12, indicated R81 had multiple diagnoses including Lewy body dementia, bipolar disorder, anxiety, mood disorder and non-organic psychosis. R81's psychotropic medication care plan dated 10/19/12, identified psychotropic drug use related to diagnoses of paranoid state, chronic bipolar disorder, anxiety disorder and psychosis as evidenced by received hypnotic, and anti-anxiety. The care plan identified R81 with an alteration in health maintenance, goal "Condition (s) will be maintained with current regimen." Care plan interventions included medications administered per physician orders, and update physician with condition changes. Review of R81's Hennepin County Medical Center Psychiatry clinic visit progress note dated 6/17/13, indicated under assessment: "2.	F 157		

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F 157	Continued From page 5	F 157		

Insomnia. Patient reports her sleep is disrupted by the tremor. I am going to go ahead and try adding Ambien 5 mg at bedtime. 4. Severe anxiety. Currently Ativan she is getting at least t.i.d. [three times a day], which she needs to control anxiety."

R81's Physician Orders dated 6/19/13, noted lorazepam (anti-anxiety) 1 milligram (mg) was to be given three times daily and another prescription dated 6/17/13, noted zolpidem (Ambien-sleep aid) 5 mg was to be given by mouth at bedtime.

During review of MAR dated 8/2/13 through 8/5/13, R81 had missed nine doses of Ativan and from 6/17/13 through 6/26/13, had missed 10 doses of Ambien.

On 8/15/13, at 10:21 a.m. consultant director of nursing (O)-D verified that the both medications had not been administered on those days and were circled with notes behind MAR for Ativan that "Ativan 1 mg not available nurse notified."

On 8/15/13, at 3:18 p.m. O-D approached surveyor stated that she had inquired from the pharmacy and that medication was not filled as there was no script from the provider even though there was a prescription sheet in R81's chart dated 6/17/13, that resident had brought to facility from appointment and had been noted on the same date.

The undated Resident Change of Condition Physician Notification policy directed "The attending physician or physician on call will be notified with changes in resident's condition or health status. 1. Between the hours of 8:00 am

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F 157	Continued From page 6 and 10:00 p.m., seven (7) days a week, attending physicians or physician on call is to be notified of all condition or health status change. 2. between the hours of 10:00 p.m. and 8:00 am. the attending physicians or physician on call should be notified of any change in condition, health status or incident that (List is not inclusive-examples only): Resulted in an injury that has the potential for physician intervention..... and significant change in mental or psychosocial status." R18's family was not notified of an injury for four days after the the facility had knowledge of an injury that occurred on 5/11/13, but was reported to the staff by the resident on 5/12/13. The Resident Admission Record dated 8/5/02, indicated R18 had diagnoses including, unspecified idiopathic peripheral neuropathy, peripheral vascular disease, and diabetes mellitus. R18's nurse's notes revealed: -On 5/12/13, on the evening shift, R18 complained of left leg pain. The leg was somewhat swollen. Resident reported that she had hit it on the medication cart the previous day 5/11/13, which the writer had no knowledge or report of incident . Resident leg was propped on pillow. writer wrote WNL (within normal limit) continue to monitor. -On 5/13/13, at 12:05 a.m. noted left leg was tender to touch and swollen. The left leg was elevated on a pillow and ice pack was applied for ten minutes and the temperature had been taken and read 98.9 (no route indicated) as noted by nurse. The physician was not notified of R18's	F 157		

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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 7 change of condition at that time. -On 5/13/13, at 6:50 a.m. nurse's notes indicated a small bruise had been noted; very minimal swelling in the left lower extremity. The resident screamed out when leg was touched and resident claimed that medication cart bumped into her on Saturday 5/11/13, but was not able to recall the time of day. No further documentation in the nurse's notes about R18's family being notified during document review. The Resident Incident Report dated 5/13/13, revealed R18 had a blue/black bruise to her left outer lower extremity as noted by nurse. R81 had continued to complain of left leg pain, leg had been noted "somewhat swollen" and had told the staff that she had hurt it on the medication cart on 5/11/13. R18's emergency family contact representative was notified 5/16/13, at 2:40 p.m. per the incident report which was four days later. During review of Physician's Order Sheet dated between 5/13/13, through 5/16/13, several orders were given by both the physician and nurse practitioner related to R18's pain/injury which included two x-ray's to the left side tibia/Fibula and left foot/ankle (which were negative). Despite all the orders received from the providers R18's emergency family contact representative was not notified on treatment plan after the orders. The annual MDS dated 4/2/13, indicated R18's BIMS (a Brief Interview of Mental Status, a tool used to measure cognition) was 11 which indicated moderate impairment. The Cognitive loss/dementia-CAA dated 4/2/13, identified R18 was able to make appropriate decisions in a structured setting, continued to relay on her sisters and brothers to help make complex	F 157		

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 157	Continued From page 8 medical decisions and had resident had no significant changes in cognition since previous review On 8/16/13, at 9:30 a.m. an interview was conducted with RN-A. RN-A stated if there was a change in resident status, the nurses are to update the nurse practitioner or the attending physician immediately and or promptly if the concern was something new and if resident was not receiving medications as ordered by the provider. RN-A further stated that family/representative always had to be notified of change of treatment and injury immediately staff identified or found out. Later, on 8/16/13, at 12:45 p.m. O-D concurred with RN-A's statement. On 8/19/13, at 11:10 a.m. an interview was completed with LPN-C. LPN-C stated the physician was supposed to be updated immediately after staff had noted R18's change of status. She remembered calling early regarding the issue when she got to the floor for her shift. She noted the previous shifts had not notified the physician as that was a change of resident condition after she completed the assessment. She further stated "You never know what it is. I just call and let them figure that out with my assessment and this is what every nurse should do and family had to notified promptly." No family notification policy provided by facility upon request.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by	F 176		

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F 176	Continued From page 9 §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess 1 of 2 residents (R1) for self-administration of medications (SAM). Findings include: During observation on 8/16/13, at 7:46 a.m. R1 was observed coming from her room and handing two respiratory inhalers (ProAir and Spiriva) to the trained medication aide (TMA)-E at the medication cart. TMA-E returned the inhalers to the medication cart. The Resident Admission Record indicated R1 was admitted to the facility on 1/16/13, with diagnosis to include chronic airway obstruction. The quarterly Minimum Data Set (MDS) dated 7/23/13, indicated R1 had and had delusions (misconceptions or beliefs that are firmly held, contrary to reality). A Brief Interview of Mental Status (BIMS) score of 15 which indicated she was cognitively intact. An alteration in thought process care plan dated 1/25/13, indicated R1 had psychomotor retardation which include blank stares and included interventions of "Repeat questions prn [as needed] if resident does not understand & be patient. Staff to re-direct prn." A Physician's Progress note dated 6/5/13,	F 176	**F 176** 1. Corrective Action: A) Resident #1 has had a Self Administration of Medication Assessment Completed. 2. Corrective Action as it applies to Other Residents: A) All residents who receive medications have the potential to be affected by this deficient practice. B) Self Administration of Medication (SAM) Assessments were completed for all current residents and all future residents will have the SAM completed upon admit and reviewed quarterly. C) Physician orders will be obtained for all current and future residents who are deemed appropriate to SAM. D) Care plans will be updated to reflect each resident's ability to SAM. E) Nursing Staff was educated on the Self Administration of Medication policy and procedure.	

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F 176	Continued From page 10 indicated R1 was "dependent on nursing for all of her cares with her limited mobility and sever psychiatric illness." The Nursing Assistant Assignment Sheet received 8/15/13, indicated R1 was "Non-compliant/resistive to cares." The June 2013 Medication Administration Record (MARs) revealed an order for ProAir two puffs every four hours as needed. The August 2013 medication administration records (MAR) were requested. Review of the August 2013 MARs indicated R1 received Spiriva and Flovent daily at 8:00 a.m. The August 2013 MARs provided, did not include an order for ProAir. Review of R1's medical record lacked evidence of an assessment for ability to SAM and lacked a physician's order to SAM. When interviewed on 8/16/13, at 8:02 a.m. TMA-E stated she gave the inhalers for R1 to do and then R1 returns the inhalers when she was done. When interviewed on 8/16/13, at 9:41 a.m. the director of nursing (DON) stated R1 did not have a SAM assessment completed. The DON stated she would expect a SAM assessment be completed and a physician's order be obtained for any resident who SAM.	F 176	3. Date of Completion: 10/3/2013 4. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. The Correction will be Monitored by: A) Director of Nursing or designee	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or	F 225		

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F 225	Continued From page 11 mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident allegations of abuse, neglect and injuries of	F 225	**F 225** 1. Corrective Action: A) Resident #41, 81, 8, 82, 1, 87, 13, 18, 56 and 23 had their Incident Report and/or chart reviewed by an RN. Care plans were updated accordingly. B) Resident #18 had her incident from 5/13 related to the medication cart and her foot reported to the State Agency/CEP on 8/12/13. C) Resident #23 had his incident related to the allegation of staff abuse reported to the State Agency/CEP on 8/14/13. D) Residents #55,85, 89, 595, 597, 598 and 599 are no longer residents of St. Olaf's facility. E) Resident #45 has a new wander guard device and it is placed in the proper area of his w/c. His care plan reflects the use of the wander guard. 2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by these deficient practices.	

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F 225	Continued From page 12 unknown origin were immediately reported to the administrator and State agency (SA), and failed to ensure allegations were thoroughly investigated for 6 of 8 allegations of abuse or neglect reviewed (R41, R82, R1, R87, R18, R23) of abuse and neglect investigated. In addition, the facility failed to report immediately to the SA for reportable events (R56) and failed to report elopements to the SA for 8 of 8 residents (R85, R55, R89, R595, R597, R598, R599). Findings include: R41 was known to have a history of sexually inappropriate behaviors towards others and R41 was found by facility staff engaging in sexual contact with another resident (R81) on 6/1/13, the incident was not immediately reported to the administrator and State agency and then investigated to rule out potential resident to resident mistreatment. On 6/1/13, at 6:30 p.m. R41's Nurse's Notes indicated, "Resident [R41] was witnessed in his room engaging in a sexual act with another resident [R81], when door opened, this resident stated 'Get out, Respect our privacy'! [sic]" The note indicated the weekend supervisor, the social service designee (SSD) and nurse practitioner were notified via telephone or had a voice message left for them. On 6/2/13, at 1:00 p.m. a Nurse's Note indicated R41 had "no sexually inappropriate behavior" noted. A note at 5:00 p.m. indicated R41's conservator was called and updated on the 6/1/13 incident. Although the clinical record indicated R41 was monitored for sexual activity and behaviors after the incident on 6/1/13, the clinical record lacked	F 225	B) The Wander Guard System policy has been revised to include how to check that the device and system are functioning. C) The Missing Resident policy was reviewed. D) The Abuse Prevention Plan has been revised to include immediate reporting language and reporting of elopements. E) A Resident to Resident Altercation policy has been added to abuse prevention policy. F) All facility staff has been educated on the revised policies. 3. Date of Completion: 10/3/13 4. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. The Correction will be Monitored by: A) Director of Nursing or Designee	

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F 225	Continued From page 13 evidence the administrator and State agency were notified immediately and lacked evidence the incident was investigated to determine if the sexual contact was consensual between both residents. R81's quarterly Minimum Data Set (MDS) dated 7/8/13, indicated R81 had anxiety disorder, delusions, manic depression and psychotic disorder (other than schizophrenia). MDS also indicated R81 Brief Interview of Cognitive Status (BIMS a tool used to determine cognition) was 10, indicating moderate cognitive impairment. R81's Cognitive loss/dementia CAA dated 10/8/12, indicated R81 had multiple diagnoses that included dementia (Lewy body), bipolar disorder, anxiety, mood disorder and nonorganic psychosis. The Resident Admission Record (undated) indicated R41's diagnoses included genital herpes, psychosis, history of cocaine, drug and alcohol addiction. The annual MDS dated 5/31/13, indicated a BIMS of 15 (no cognitive impairment); identified physical behaviors occurring 1-3 days and verbal behaviors 4 to 6 days in the assessment period; he required extensive assistance with bed mobility, dressing, toileting, dressing, personal hygiene. The MDS identified R41's behaviors interfered with participation in activities, put others at significant risk for physical injury, significantly intruded on the privacy or activity of others, significantly disrupted care or living environment. The MDS indicated R41 rejected care 1 to 3 days during the assessment period and he had no mood indicators. The CAA for cognitive loss/dementia dated 5/31/13, identified R41 had verbal behaviors, physical behaviors directed at others,	F 225		

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F 225	Continued From page 14 rejected cares, had a diagnosis of paranoid schizophrenia and had a "guardian in place." The CAA identified R41 had delusional thinking and a history of refusing cares. The activities of daily living (ADL) Functional Status/Urinary Incontinence/Pressure ulcer CAA dated 6/14/13, identified R41 used an electric wheelchair for locomotion. The psychotropic medication CAA dated 6/14/13, identified R41 used Abilify for the diagnosis of paranoid schizophrenia, and Haldol and Ativan as needed. R41 was identified to have hallucinations which affected his mood and behaviors. The CAA for communication dated 6/14/13, identified R41 ability to understand others was impaired and R41 may miss some part/intent of a message. The care plan dated 6/4/13, identified R41 had a history of sexual/sexually inappropriate/disruptive behavioral symptoms due to a diagnosis of paranoid schizophrenia, a history of having pornography in his room, a history of masturbating in his room, a history of making advances towards other staff and residents. The care plan directed to "assess whether the behavior endangers the resident and/or others. Intervene as necessary. The care plan identified R41 was seen by outpatient psychology. The care plan identified to remove R41 from other resident rooms. The care plan identified R41 had physically abusive behavior symptoms and directed interventions to address physically abusive behaviors. The care plan identified R41 was at risk for harm from self or others related to diagnosis of paranoid schizophrenia, paranoid thoughts, delusions, and moderate impairment. The care plan directed completion of vulnerability assessment and abuse reporting. The care plan identified R41 had delusions, verbally abusive	F 225		

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F 225	Continued From page 15 behaviors, resisted cares, and had altered thought process. A physician's progress note dated 7/16/13, identified, "Schizophrenia - Severe paranoia remains. Acting out sexual behaviors have been difficult for staff - sex w/ [with] another resident/inappropriate comments [sic] & touch. D/C [discontinue] Depakote as it may be causing some disinhabition [sic]." On 8/16/13, at 10:26 a.m. SSD-A stated she felt R41 could be an "aggressor" because of his "explosive personality." SSD-A stated R41 "goes out for psych [psychiatric] services," and R41 had a new psychiatrist involved. SSD-A stated psychiatric appointments were scheduled for R41. SSD-A stated R41 had "multiple" reports to the Office of Health Facility Complaints, the State agency (OHFC, SA)." SSD-A described R41 has having "lunged" at and struck out at SSD-A; having lunged at and struck out at other residents, that R41 required crisis intervention for escalating behaviors in the past. SSD-A described "other resident's aren't safe" around R41. SSD-A verified R41 was not being monitored and able to move freely throughout the facility. On 8/19/13, at 11:32 a.m. the director of nursing (O)-G, registered nurse (RN)-A, and nurse consultant were notified of the 6/1/13, nurses note which indicated R41 was found having a sexual encounter with another resident. O-G stated she believed she "may be" aware of whom (the other resident was), but was unclear. Information regarding the incident was requested. The consultant RN checked the "Fall Tracking" log and stated it was not recorded there.	F 225		

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F 225	Continued From page 16 - At 2:12 p.m. the surveyor, O-G and SSD-A met regarding R41's 6/1/13 incident. O-G verified R41 was found by facility staff to be engaging in a sexual act with R81 in R41's room. SSD-A and O-G stated when staff discovered R81 with R41, the residents requested privacy, they were left alone in the room, the nurse supervisor was notified and SSD was called. O-G and SSD-A stated both of the residents' guardians and family were contacted; nurse practitioners (NP's) for both were updated. Both O-G and SSD-A stated R41 was alert and oriented and able to make "that choice" and stated R81 had a mental illness, R81's BIMS was "15 [even though the last BIMS indicated a lower score and moderate impairment]." Both stated although R81 had a mental illness, R81 was able to "state no or consent." Both staff stated R41's guardian was okay with the contact and R81's guardian referred the question R81's mental health worker. SSD-A stated the mental health worker was more familiar with R81 having worked with R81 "through the commitment process." O-G stated R81 was identified to have a "long history sexual activity." Both verified no incident report was completed regarding the incident. O-G stated R41's diagnosis of genital herpes was "latent" and unclear if he was actually having problems as he completed his own cares and staff did not observe his genitalia. O-G stated the facility was ordering a HSV test (a test for genital herpes) for R81. The SSD-A stated verbally she called and notified the administrator as soon as she received the voicemail and was aware of the incident, but was unclear when that was. The O-G and SSD-A both confirmed no investigation was completed after the administrator was notified and verified at no time was the State agency contacted. Although the incident was not investigated to	F 225		

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F 225	Continued From page 17 determine resident consent, both felt the incident was not reportable due to both residents being "consensual." On 8/20/13, at approximately 11:15 a.m. R81's guardian (G)-A was contacted via telephone and verified she was aware of the 6/1/13 incident on 6/2/13. G-A stated R81's family was notified of the incident and all parties believe the contact was consensual. At approximately 3:00 p.m. the guardian (G)-B for R41 was contacted via telephone and confirmed he was notified of the 6/1/13 incident on 6/2/13. G-B stated he believed the contact was consensual. Both G-A and G-B were reluctant to discuss the details of the incident, but expressed they felt adequately notified of the incident. Both stated R41 and R81 had long histories of eliciting sexual contact. R82 was found to have vaginal bleeding of unknown cause which was not reported. The quarterly MDS dated 3/6/13, indicated R82 had severely impaired cognitive skills for daily decision making. Review of the Nurse's Notes dated 4/14/13, revealed R82 had blood on the buttocks. The Nurse's Notes also indicated "no cut areas noted possible had vaginal bleeding." There were no other Nurse's Notes regarding the possible vaginal bleeding. The NP note dated 4/19/13, indicated the blood observed on 4/14/13, was dark red, was noted to run down R82's legs and a urinalysis/urine culture (UA/UC) was negative. When interviewed on 8/16/13, at 8:44 a.m. SSD stated she was not aware of R82's potential vaginal bleeding and the occurrence was not reported nor investigated. SSD indicated she would expect vaginal bleeding would be reported.	F 225		

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F 225	Continued From page 18 SSD also stated R82 was not delusional, just disorganized and confused. The licensed practical nurse (LPN)-I, who wrote the Nurse's Notes dated 4/14/13, was unavailable for interview. Review of the facility Abuse Prevention Plan For Minnesota Skilled Nursing Facilities dated 6/6/13, unexplained vaginal bleeding was included as a possible indicator of abuse. In addition, the Abuse Prevention Plan For Minnesota Skilled Nursing Facilities indicated an injury is considered an injury of unknown source and must be reported when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent or location of the injury. R1's allegations of another resident making sexual advances were not reported. The Resident Admission Record indicated R1 was admitted to the facility on 1/16/13, with diagnoses to include brain injury, lupus, osteoarthrosis, lumbago, diabetes, morbid obesity, schizophrenia, and epilepsy. The quarterly MDS dated 7/23/13, indicated R1 had a BIMS of 15 which indicated cognitively intact. A care plan dated 1/25/13, indicated R1 was at risk for harm from self and others and would remain free of harm or injury from self or others. A physician's progress noted dated 3/13/13, indicated R1 was a poor historian in that she had severe mental illness but knew how she felt. A Referral Form dated 6/13/13, from the psychiatrist indicated R1 was alert and oriented in three spheres and had no signs of psychosis.	F 225		

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F 225	Continued From page 19 A Nurse's Notes dated 6/29/13, indicated R1 was "moody" and reported she felt a nursing assistant (NA) was making fun of her. The note indicated the NA later apologized to R1 and R1 gave the NA a necklace. A Nurse's Notes dated 7/1/13, noted R1 appeared upset and was crying and stated another resident had offered her money for sexual pleasure. The note indicated R1 stated she felt bad and had flash backs of bad things that had happened to her as a child and that she wanted to talk to the social service designee about moving to another floor. When interviewed on 8/13/13, at 12:59 p.m. R1 reported she had been propositioned by other residents at the facility for sexual activity. R1 stated she tells the other residents no and they won't leave her alone. R1 reported she had told staff about the incidents and the most recent incident occurred last month. A social service progress noted dated 7/16/13, indicated R1 had made a complaint against another resident. The note indicated R1 reported another resident had come into her room and asked her for sexual activity. The note further indicated an investigation was started and the accused resident had been out of the building at the time. When R1 was re-approached, she stated she "made it up." A social service progress note dated 7/24/13, indicated R1 had a history of false accusations against staff and other residents surrounding sexual behavior. When interviewed on 8/16/13, at 12:50 p.m. SSD-A indicated she did not investigate the 7/16/13, incident because the accused resident had been out of the building at the time of the allegation. SSD stated she was not aware of the incidents on 6/29/13, and 7/1/13, and verified the	F 225		

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F 225	Continued From page 20 incidents had not been investigated nor reported to the State agency. SSD stated staff was expected to report allegations immediately. R87 was noted to have dark purple bruising on the knuckles of the left hand and dark purple bruising to the right wrist area during an observation on 8/12/13, at 5:42 p.m. When asked, R87 reported she fell down the stairs. During observation on 8/15/13, at 9:16 a.m. R87 continued to have the bruising to the left knuckles and the right wrist and another 7 centimeter (cm) x 4 cm dark purple was noted to R87's left forearm. On 8/19/13, at 10:06 a.m. R87 was observed to have a dark purple, thumb sized bruise on her left inner forearm. The Resident Admission Record indicated R87 was admitted to the facility on 12/5/12. R87's diagnoses noted on the nurse practitioner progress noted dated 7/16/13, included Alzheimer's disease with paranoia and delusions, anxiety disorder and hypertension. The admission MDS dated 12/18/12, indicated R87 had both short and long term memory problems and moderately impaired cognitive skills for daily decision making. R87's care plan dated 12/13/12, identified her as being at risk for harm from self or others related to a diagnosis of dementia. The care plan does not identify risk for bruising or bleeding. In addition R87's care plan indicated she was resistive to cares with an approach to include	F 225		

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F 225	Continued From page 21 "When resident begins to resist care, STOP and try task later. Do not force to do task." R87 was observed on all days of the survey to be sitting and walking with R82. R82's Behavior/Intervention Monthly Flow Record for August 2013, noted R82 was monitored for "abusive to others" which was noted as occurring two to three days on day shift from 8/7-8/12/13. A Resident Incident Report dated 3/27/13, noted a 4 cm x 5 cm bruise to R87's outer left hand. The immediate interventions were noted as monitor and redirect and requested geri-sleeves from the nurse practitioner. RN assessment indicated trial of geri-sleeves was unsuccessful and to monitor areas and encourage resident not to grab hands, just hold hands. A Nurse's Notes dated 4/29/13, indicated more bruises noted to body, blue and yellow in color. The last Resident Incident Report was dated 3/27/13. A Resident Incident Report dated 6/14/13, 7:00 a.m. indicated R87 was noted to have a 1.5 cm x 2.5 cm bruise on the left wrist. Interventions noted to monitor skin daily and monitor for and redirect when residents holding arms/wrists to hold hands. A Nurse's Notes dated 7/6/13, noted multiple bruises on both (unidentified area) remained. A Nurse's Note dated 7/20/13, indicated R87 had old bruises on both lower arms. Review of the Resident Incident Reports and the Nurse's Progress notes revealed no documentation regarding these bruises. A physician's order dated 7/29/13, directed to	F 225		

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F 225	Continued From page 22 monitor skin every shift and document new areas in the nurses notes. Review of the Nurse's Notes revealed no documentation of bruising from 7/29-8/19/13. On 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. On 8/16/13, at 11:11 a.m. the nurse consultant stated bruises were tracked on incident reports. On 8/19/13, at 2:09 p.m. O-G was again asked for documentation regarding assessment and intervention for R87's bruises noted throughout the survey. Review of the Nurse's Notes dated 4/8/13, revealed R87 was found to have multiple bruises during evening cares. The bruises included a 3.5 centimeter (cm) x 5.5 cm to her back, a 2.5 cm x 3.8 cm to the left hand, and a 7 cm x 6.5 cm to the right hand. The Nurse's Notes indicated staff was unaware of how the resident sustained the bruises. All Resident Incident Reports for R87 were requested and one was not provided for 4/8/13. There was no indication that R87's bruises of unknown origin were investigated or reported as required. When interviewed on 8/16/13, at 8:43 a.m. SSD-A indicated all bruises below the shoulder were to be reported for R87. During a random observation on 8/16/13, at 11:23	F 225		

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F 225	Continued From page 23 a.m. NA-I was observed to grab another resident R38 on the left arm between the wrist and elbow to lead her to the table. The director of nursing was notified. R8's Resident Admission Record dated 1/10/08, indicated R8 had diagnoses of adjustment disorder with depression, anxiety, convulsions, muscle spasm, infantile palsy, stroke with hemiplegia (loss or decreased use of one side of the body), contracture, dystonia (lack of muscle control), and narcissistic personality disorder with anti-social traits. The resident had a plan for extreme verbal and physical abuse that included, to be removed from the facility by a call to 911 to send resident to the Hennepin County Medical Center (HCMC) crisis intervention unit. The facility lacked a behavior management plan and/or behavioral programing for R8 to prevent repeated verbal and physical abuse to staff and peers. R8's care plan initiated 9/29/08, indicated vulnerable adult at risk for harm to self or others, inappropriate behavior and altered mood state related to nursing home placement, anger with staff, verbally abusive/name calling, refusing cares, disruptive behaviors in common areas, swearing and yelling in dining room, physically arguing with staff and others. R8 was noted to be very impulsive and easily angered by other residents, verbally abusive and resistive with cares, received anti-psychotic, anti-depressant, and anti-anxiety medication as needed. The care plan indicated R8 had the tendency to perseverate on medical concerns, his eye glasses, etc. Interventions listed were to offer choices, remind him name calling was not appropriate or acceptable, attempt re-direction,	F 225		

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F 225	Continued From page 24 and re-enforce his capabilities and competencies. Remove him to his room to calm down as needed, set limits with, leave him to cool off when he was verbally aggressive and check back. remind him to speak softer, call 911 and send to crisis (intervention unit when needed). Leave more space between tables in the dining room and fellowship hall, discuss keeping the peace, listen to concerns, express appreciation for efforts to be a gentleman, re-enforce positive outcomes. Discuss his role as on advocate throughout his life; discuss how others have positively impacted his life (wife who passed away). Kill with kindness approach, psychology following as needed, encourage him to do his puzzles. Inform resident's sister of behaviors. Complete vulnerability assessment per policy; continue to post abuse reporting form with staff and Hennepin Counties number. All staff [are] annually trained on abuse reporting. The care plan included reporting abuse to Hennepin County but lacked direction to report to the SA. The significant change Minimum Data Set (MDS) dated 6/7/13, revealed a Brief Interview for Mental Status (BIMS) score of 11/15, which indicated moderate cognitive impairment and included evidence of delirium - psychomotor retardation that comes and goes. R8 required extensive assistance and two person physical assist with bed mobility and transfers, extensive assistance of one person for dressing, personal hygiene, toileting, and locomotion off the unit, and was independent in locomotion on the unit. The MDS indicated R8 had verbal behaviors directed towards others one to three days and physical behaviors one to three days in the look back period. The Care Area Assessment (CAAs) triggered behavioral symptoms, which was not	F 225		

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F 225	Continued From page 25 addressed in the CAAs narrative summary. The incident reports for R8 were reviewed from 8/27/12, going forward and the following was noted: - On 8/27/12, during an altercation over the television (TV) in the third floor dining room, R8 struck R78 on the hand leaving a 3.0 centimeter (cm) by 1.5 cm bruise. R78 stated he "was watching a TV program at 7:00 p.m. and [R8] came into the dining room and wanted to watch TV, I told him I was already watching a program and would change it at commercial time, he [R8] started yelling at me so I tried to go back to my room, but he hit me on my hand!." R78 returned to his room and at 10:30 p.m. reported to the floor nurse that R8 had struck him. The report to the SA on 8/28/12 (one day late), indicated a registered nurse (RN) responded to yelling in the dining room and saw a nursing assistant (NA) prevent R8 from charging R78. The investigative report was submitted 8/30/12, and noted R8 stated "I got so mad that I just hit him!." The report indicated R8 had a history of physically aggressive behavior towards staff and other residents at the nursing home. R8 had both in house psychologist on an as needed basis and a psychiatrist in the community. Staff followed the care plan, they are to protect residents and themselves, move other residents away from R8 to safety and call 911 to send R8 to HCMC crisis unit if R8 was non re-directable. The SSD had also spoken with the primary doctor (MD) regarding alternative placement in the community that would better suit R8's behaviors. The SSD will make a referral for relocation services for a more appropriate environment. - On 9/9/12, (un-timed) R599 reported to staff that R599 attempted to help another resident pick	F 225		

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something off the floor on ground level. R8 asked R599 to move out of his way. When R599 did not move fast enough, R8 became mad and elbowed R599 in the arm and attempted to push him out of the way. The incident was reported to the SA on 9/10/12 (one day late). The investigative report submitted 9/13/12, indicated care plan interventions were followed for both verbal aggressive behaviors and physical behaviors. Residents were immediately separated and R8 was asked to lower his voice. R8 had other incidents at the facility. "(A) 911 protocol is in place for R8, staff was aware to contact 911 and send R8 to HCMC crisis unit if behaviors are unmanageable." The SSD was in the process of requesting Hennepin County relocation services to assess to see if R8 was appropriate for a group home setting. R8 was also seen by the in house psychologist on 9/10/12, for behavior management.

On 12/31/12, MDH report at 8:00 p.m. revealed "R8 did not agree with other residents in the dining room that the TV channel should be changed and verbally threatened R76, another resident on 3rd floor that was present in the dining room. The incident was reported to the SA on 1/1/13 (one day late).

On 8/12/13, at 1:00 p.m. R8 requested an interview with surveyor, and stated his name was being slandered by a resident that said he had abused her. R8 was sitting at a dining room table watching a movie, with his puzzle books and mail on the table. The ombudsman name and phone number was provided to R8.

On 8/12/13, at 8:00 p.m. R8 was observed to have a verbal outburst at the peer he said was

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F 225	Continued From page 27 slandering him, and became agitated, leaning forward repeatedly in his wheelchair, towards the peer, staff intervened and attempted to redirect the resident who continued his verbal outburst. R8 was again at a third floor dining room table watching a movie with his puzzle book nearby. On 8/14/13, at 6:00 p.m. R8 was observed to have a verbal outburst in the dining room on the third floor, during the dinner meal. The staff was not able to redirect R8 and the DON had to intervene to calm R8. On 8/16/13, at 8:43 a.m. the SSD stated she was not aware of the physician comment that this was not the appropriate setting for R8, and stated she had been attempting to get ammunition to get a 30 day discharge. The SSD stated she had requested a behavioral management plan for R8 and was told to move the other residents out of the dining room, but the other residents refuse to go, because they are not doing anything wrong. The SSD stated that R8 is very territorial and had refused to watch the TV in his room. The SSD was not aware that R8's care plan did not address physical aggression other than the call to 911 to remove R8 from the facility. The SSD further stated that when R8 acts out and she had restricted him to his room, she will come back into the facility and find R8 in the dining room, because the plan (written in the communication book) had not been followed by staff. The SSD further stated R8's behaviors dissipated when he was ill in May and June 2013 and the facility had attempted to find other placement for him, but he refused and stated he wanted to be here and the family wants him here and participate in care conferences, but say "how can he get away with this behavior." The psychologist ' s	F 225		

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recommendation was to remove others from the environment, but they refuse since they are not misbehaving. When 9-1-1 was called, they do not always take him out to HCMC; if he refuses they leave him here.

On 8/12/13, at 5:20 p.m. the administrator, DON, SSD, and RN nurse were in the DON office and verified that R8 had had an altercation, yelled at and struck R78, the abuse was reported on 8/24/13, and was then reported to Hennepin County and the State agency (SA), in addition they also verified the statement of R78 that the perpetrator (R8) had "verbally and physically attacked" other people and had been "crisised out of the building" (by calling 9-1-1) several times, received inpatient psychiatric stays and medication changes, and had been allowed back into the facility.

R599's Resident Admission Record dated 8/20/12, noted R599 had diagnoses of persistent mental disorder, altered mental status, diabetes, a right below the knee amputation, gait abnormality, and active drug abuse.

The care plan dated 9/19/12, indicated R599 required assistance of staff to stabilize during transition from sitting to ambulation or for transfers.

R599 left the facility (elopement) without orders or medications during the week of 11/23/12, according to the Report of Suspected Abuse or Neglect of Vulnerable Adults form. R599 was hospitalized (at an unknown date and time) secondary to no medications.

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F 225	Continued From page 29 On 1/3/13, the elopement was reported to Hennepin County as "against medical advice discharge after 41 days." It was unclear what day the resident left the building. The elopement was not reported to the SA for eight months. The facility did not report the elopement after the surveyor intervened. R598's Resident Admission record dated 7/24/12, noted 598 to have diagnoses of liver cirrhosis with ascites (enlarged liver with fluid backup into the abdomen), a history of heart bypass surgery, congestive heart failure (fluid backup into the feet and legs) and diabetes. The care plan dated 8/1/12, noted R598 had a risk of falls due to loss of balance during transitions. R598 had verbally abusive behavioral symptoms, and had threatened and screamed at others. R598 left the facility (elopement), without orders on 1/3/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. R598 left in the company of his daughter stating "get me the (profanity) out of here." R598 did not return to the facility. The facility did not report the elopement to the SA. R85 was admitted on 8/14/12, with admission data base diagnoses of chronic kidney disease, hypertension, learning difficulty, homelessness, socially inappropriate and disruptive behavior. The MDS dated 2/19/13, indicated R85 was cognitively intact and independent in all activities of daily living.	F 225		

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F 225	Continued From page 30 The care plan updated 8/5/13, indicated a self-care deficit, socially inappropriate behavior in the dining room (yelled and threw things), and resisted cares and medications. R85 left the building without signing out (elopement) during the evening on 1/8/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. It was unclear when the administrator was notified (un-timed). It was unclear when it was reported to Hennepin County (un-timed) and a statement was added to say the resident returned to the facility on 1/9/13, at 7:00 p.m. Hennepin County was updated on 1/10/13. There was no indication of a police report of a missing person report being filed. The facility did not report the elopement to the SA. R597's Resident Admission Record noted 597 to have diagnoses which included multiple rib fractures from a fall, congestive heart failure (fluid backup into the lungs), chronic obstructive pulmonary disease (lung disease), diabetes, and depression. No assessments were completed for R597. An admission care plan dated 1/28/13, indicated R597 used a cane to ambulate. R597 left the facility, "stating he did not want to stay" (elopement) on 1/30/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. The facility did not report the elopement to the SA.	F 225		

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F 225	Continued From page 31 R89's MDS dated 2/20/13, indicated moderately impaired cognitive skills for daily decision making-decisions poor, cues/supervision required. R89 required extensive assist of two with bed mobility and transfers, extensive assist of one for dressing, personal hygiene and toilet use. A care plan for R89 was requested and not provided. R89 left the facility on 2/25/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. R89 left with his family (elopement) after being told there were no orders for a leave of absence, he did not return to the facility. That was reported to the director of nursing (DON) on 2/25/13. The facility did not report the elopement to the SA. R55 left the facility twice without supervision. The MDS dated 4/24/13, indicated intact cognition. R55 required assist of one with bed mobility, dressing and toilet use, supervision with transfers, and set up for personal hygiene. R55 required assist of one with bed mobility, dressing and toilet use, supervision with transfers, and set up for personal hygiene. The Brief Interview for Mental Status (BIMS) 4/24/13, indicated a BIMS score of 15/15 - which depicted intact cognition. On 4/25/13, at 11:00 a.m. R55 signed out of the building but did not return (first elopement). On 4/26/13, at 8:00 a.m. a Report of Suspected Abuse or Neglect of Vulnerable Adult form was filled out. Hennepin County was notified on	F 225		

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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 225	Continued From page 32 4/26/13, at 8:33 a.m. the medical doctor (MD) was notified (un-timed) and gave parameters if resident not back in 24 hours to do an against medical advice discharge. Police were notified (undated and un-timed). On 4/26/13, "in the evening hours" (un-timed) the resident returned to the facility and Hennepin County and Police were notified of the return. The elopement was not reported to the SA. On 5/6/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form, R55 left the facility without supervision, and did not return (second elopement). Hennepin County was notified on 5/7/13, at 2:08 p.m. a report to the police (undated and un-timed) was attached to the form. On 5/7/13, at 11:34 p.m. the resident returned to the facility. The elopement was not reported to the SA. R595's Resident Admission Record dated 5/31/13, R595 was noted to have diagnoses which included bi-polar adjustment disorder (mental illness). No assessments were completed. R595 stated they were going for a walk and did not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. Hennepin County was notified on 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not reported to the SA. Documentation for R595 was requested and not provided.	F 225		

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 225	Continued From page 33 On 8/16/13, at 8:43 a.m. the SSD (the person identified for abuse concerns) stated staff would report immediately to administrator, the DON, SSD, Hennepin County and the SA. If there was an allegation of abuse, staff were removed until the investigation was completed, and then the results of the investigation were reported to administrator, Hennepin County and SA. When the late reporting was discussed, the SSD did state that she had created and provided education on how to report for the staff, but she continued to work with them on timely reporting since the staff wait for her to report. The SSD further stated that she had been directed by prior administration not to report the above cases to the SA, even though she questioned the situations. The SSD had been working on improvement of the abuse tracking log and the grievance log. The SSD further stated that the DON investigated complaints against the staff and the SSD investigated the others, such as resident to resident altercations. All allegations of sexual abuse, corporal punishment, etc. would be investigated. When asked why the resident to resident altercations and elopement were not in the policy, the SSD stated that's a corporate policy you'll need to speak to the administrator and DON. On 8/12/13, at 7:55 p.m. a request for all of the reported and non-reported Vulnerable Adult forms was made to the facility administrator, director of nursing O-G and SSD-A, as abuse had been identified during stage one survey by all four surveyors. O-G stated they would have the files available for review in the morning, and she was not surprised by the request. On 8/14/13, at 6:23 p.m. administrator and O-G	F 225		

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F 225	Continued From page 34 were notified of IJ, explained F323 was due to supervision and lack of system with the Wanderguard for R45. The particulars with the abuse policy were reviewed, and the difference between State and Federal language in the abuse policy was explained. The facility policy contains a paragraph titled situations that are not abuse and defines therapeutic conduct, which was not allowable in the federal language, and included a statement of consensual sexual personal relationship whether it existed prior to the care giver relationship or not. The word maltreatment was identified as state language and the word mistreatment was identified as the federal language. In addition the policy lacked a statement of resident to resident altercations or elopements as potential abuse or neglect. The facility policy contained an Appendix (B) that contained signs and symptoms of abuse and neglect, the facility failed to operationalize the abuse and neglect policy and report events that the policy or appendix identified as abuse or neglect and failed to report to the state agency even when it reported to Hennepin County. The administrator stated the policy was an Ecumen corporate policy and they would need to have corporate make any changes to the policy. 8/16/13 at 8:43 a.m., SSD-A the person identified for abuse concerns stated staff would report immediately to administrator, the O-G and SSD-A, Hennepin County and the SA. If allegation of abuse staff were removed until the investigation was complete, then report to Administrator, Hennepin County and the SA the results of the investigation. When the late reporting of elopements was discussed SSD-A did state that she had created and provided education on how to report for the staff, but she	F 225		

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F 225	Continued From page 35 continued to work with them on timely reporting, since they wait for her to report. SSD-A stated that she had been directed by prior administration not to report the above elopement cases (provided by the facility in the non-reportable file) to the SA, even though she questioned that. SSD-A had been working on improvement of the abuse tracking log, and the grievance log. SSD-A further stated that the director of nursing investigated complaints against the staff and she investigated the others, such as resident to resident altercations. All allegations of sexual abuse, corporal punishment, etc. would be investigated. When asked why the resident to resident altercations and elopement were not in the policy, SSD-A stated "that was a corporate policy you'll need to speak to the administrator and O-G." -At 9:30 a.m. SSD-A stated to surveyor she was involved with the elopements when they were brought up in the IDT [interdisciplinary team] meetings. SSD-A verified she completed the mood and behavior sections of the care plan. The Elopement Assessment policy and procedure dated as revised on 5/15/13, identified the facility policy was to assess each resident to identify potential risk factors for elopement. The policy identified, "All residents will be assessed on admission and annually for elopement. That resident determined to be 'at risk' for elopement will be assessed quarterly." The policy directed the completion of the "Elopement Risk Assessment [Risk of Elopement/Wandering Review]." The policy further directed to apply appropriate interventions from the "list" at the bottom of the form, directed to complete an "elopement prevention/management care plan." The policy further directed, "8. If Wanderguard is	F 225		

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F 225	Continued From page 36 an intervention. Test Wanderguard to ensure it [sic] working properly before putting on resident. 9. Implement signaling device testing calendar, test Wanderguard daily and sign daily that it is tested and working." The Ecumen Incident Reporting-Resident policy dated August 2003, and last reviewed and revised September 2011, revealed: 1. An incident report is completed whenever an incident occurs. An incident is defined as an actual or potential injury to resident. Incidents include, but are not limited to, an observed or unobserved fall, skin tear, physical altercation between residents or a resident and non-resident, elopement (leaving of facility without following facility policies) or evidence of trauma or physical, mental or sexual abuse. Incidents also include an injury of an unknown source. An injury of an unknown source occurs when 1) the source of the injury was not observed by any person or the source of the injury could not be explained by the resident and 2) the injury is suspicious because of the extent of the injury or the location of the injury (for example, the injury is not located in an area not generally vulnerable to trauma) or the number of injuries at one particular point in time or the incidence of injuries over time. 2. A separate incident report for each resident involved in an incident shall be completed. 3. As soon as possible after an incident, a licensed employee with knowledge of the incident completes the first page of the Resident Incident Report (LPN, RN, social service designee, RPT, etc.). Incidents of suspected Maltreatment as defined in Ecumen's Abuse Prevention Plan are reported to the director of nursing (DON) and Administrator immediately. A licensed nurse must	F 225		

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F 225	Continued From page 37 complete the 24-hour. Follow-Up. An RN must complete the "Post Incident Analysis". 4. The information on the Resident Incident Report is recorded in ink. 5. Entries are dated and timed. Signatures on the incident report include full name and title. 6. The appropriate family members and physician are notified in a timely fashion of the incident. The resident, resident's physician, and resident's legal guardian or interested family member are notified as soon as possible if there is: -An accident involving the resident which results in injury and has the potential for requiring physician intervention; -A significant change in the resident's physical, mental, or psychosocial status (i.e. a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); -A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or -A decision to transfer or discharge the resident from the facility. 7. The incident report remains on the unit for 24 hours to facilitate completion of the report which is then forwarded to the DON. The signed original incident report is kept in separate file as designated by facility (do not copy or place incident form in the resident's medical record). -For missing residents or suspected elopement of residents, a Resident Incident Report is completed IN ADDITION to following the "Missing Resident" policy and procedure..... -Incidents of missing residents, suspected or actual elopement or medication error must be reviewed for possible neglect pursuant to	F 225		

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F 225	Continued From page 38 the facility Abuse Prevention Plan..... R18 alleged a facility employee had bumped her foot into the medication cart on 5/11/12. The resident admission record indicated R18 was admitted to the facility on 8/05/02. R18's diagnoses included cerebra vascular accident (CVA) with left hemiplegia, chronic kidney disease, unspecified idiopathic peripheral neuropathy, peripheral vascular disease unspecified, adjustment disorder with mixed disturbance of emotions and conduct, osteoarthrosis generalized involving multiple sites, blindness one eye not otherwise specified, sickle-cell disease unspecified, diabetes mellitus uncomplicated type II and unspecified drug dependence unspecified use. R18's Annual MDS dated 4/2/13, indicated R18's BIMS was 11 out of a possible 15 points for cognitive patterns. The Cognitive loss/dementia Care Area Assessment (CAA) dated 4/2/13, identified R18 was able to make appropriate decisions in a structured setting, continued to relay on her sisters and brothers to help make complex medical decisions and had resident had no significant changes in cognition since previous review. R18's care plan dated 4/16/12, identified R18 at risk for harm from self or others with goal "will remain free of harm or injury from self or other....." When interviewed on 8/12/13, at 3:53 p.m. expressed concerns of abuse by a facility	F 225		

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F 225	Continued From page 39 employee. R18 indicated that NA-H had bumped her foot on the medication cart which resulted to a lot of pain and she had been also admitted to the hospital. R18 stated "after the incident I was asked a lot of questions but as long as I knew nothing had been done as the staff still comes around me to provide care, am very scared and afraid of this staff even to ask her to comb my hair. I now have to wear my wig as am not able to comb my hair, when she comes into my room now she always comes with another staff." R18 also added "I have a big mouth and this would get her in trouble most of the time in the facility especially with staff." On 8/12/13, at 5:16 p.m. surveyor reported the allegations to the facility administrator, director of nursing (O)-G, registered nurse (RN)-A, and SSD all at the time in O-G office. SSD-A stated that R18's complaint had been received, investigated and was considered not reportable to the SA and R18's care plan had been updated with focus for making fools allegations about staff which fell in this case when she made the allegation staff had run over her toe. SSD-A further added to say that the incident had happened on 5/11/13, investigation was started on 5/13/13 and resident was sent out to the hospital on 5/18/13, for evaluation related increase edema, elevated temp, and redness to extremity. At the end of the meeting the administrator asked SSD-A to report this allegation to SA immediately 8/12/13. During review of the internal facility investigation it indicated: R18 had reported on 5/12/13, on the evening shift that she hit her foot on the medication cart on the previous day as a staff was getting her into the elevator. The resident complained of pain in her left foot at that time.	F 225		

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F 225	Continued From page 40 The resident nor any other staff reported this to the nurse at the time the resident says her foot was bumped. On 5/13/13, AM shift an order was received from the MD to complete an x-ray due to some edema and continued complaint of pain to the left foot. The x-ray was taken on 5/13/13 of the tibia/fibular (Leg bones) which was negative for a fracture but indicated there are rather pronounced degenerative changes within the knee. Staff interviews were conducted for the staff that had been in the area when the resident says her foot was bumped reported they had not witnessed the resident getting her foot bumped on 5/11/13, nor did the resident report this to any staff at that time. On 5/13,/13, R18 was interviewed and continued to complain of pain to the left foot. The left foot was inspected no bruising was noted but the ankle area was slightly swollen. Several orders were given by the provider in relation to addressing the pain but eventually on 5/18/13, at 0025 the resident was sent to the emergency room (ER) due to left ankle pain, edema (swelling) and with a low grade temperature. R18 was admitted to the hospital for cellulitis of the left lower extremity, Gout and chronic kidney disease. On the investigation it was determined there was no abuse or neglect found. The investigation was signed by administrator, SSD-A, consultant director of nursing (O)-D and interim director of nursing. On 8/16/13, at 12:51 p.m. interviewed O-D stated "resident reported the incident on May 12th to Myisha; I knew of the incident on the 13th Monday and started the investigation for the allegation." O-D also stated the issue was not reported because the resident was not consistent with her story as R18 told her that the toe was bumped on the medication cart and changed the	F 225		

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F 225	Continued From page 41 story to something else the wheelchair. The issue was brought to the inter disciplinary team which decided it was not reportable because at the time of the night when it happened per resident she never said anything until the next day and then changed her story. Also O-D added that the R18 she believed it was an accident and not abuse. NA-H involved in this allegation was never taken off the schedule during the investigation and was later given verbal counseling. Although the facility did report R18's allegation to the SA about NA-H bumping her foot, the facility never addressed in the report submitted to the SA on 8/12/13, R18's report of being scared and afraid of the caregiver to the point of not being able to ask for assistance with cares as the caregiver continued to provide cares to R18. R23 alleged a facility staff had been aggressive during cares. The resident admission record indicated R23 was admitted to the facility on 10/27/08. R23's diagnoses obtained from the quarterly MDS dated 6/24/13, included CVA with right sided hemiplegia, diabetes type II, depression, hypertension, and seizure disorder. The MDS dated 6/24/13, identified R23's BIMS was 10 out of a possible 15 points for cognitive patterns. The vulnerability care Plan dated 10/13, identified R23 was at risk for harm from self or others related to CVA, depression, loss of homeland and being forgetful. Goal "Resident will remain free of harm or injury from self or other....." When interviewed on 08/12/2013 4:38 p.m. R23	F 225		

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F 225	Continued From page 42 stated "This aide I don't know her name came and left me in the toilet. She is also aggressive. Pulls me and never really cares. I cannot use my right side and she always leaves me alone on the toilet. I told the head nurse." On 8/12/13, at 5:16 p.m. surveyor reported the allegations to the facility administrator, O-G, RN-A, and SSD-A all at the time in O-G office. At the end of the meeting the administrator asked SSD-A to report this allegation to the SA immediately. During review of internal facility investigation it was noted that the resident had made a statement indicating aid was rough handling him. Resident was able to identify NA-H, R18 also stated "approximately a month ago she was too hard with me transferring me off the toilet, she did this because I am black, we are from the same country, she is rude, I have daughters of my own, I am not her father. "Resident also stated NA-H had not worked with him since the incident. Upon interviewing NA-H she stated she never had any issue with resident. Resident also stated NA-H frequently took care of him and that he was not a morning person. The follow up undated and unsigned note indicated that during the time the incident happened resident was transitioning from using an EZ-stand (machine used to transfer) to staff assisting with transfers and staff needed to use extra momentum with belt to pivot as resident gained strength. The note indicated no abuse was validated, staff was met with and education was present and no disciplines on file. On 8/16/13 at 12:25 p.m. interviewed SSD-A stated all complaints are supposed to be reported immediately to the SA and faxed to Common	F 225		

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F 225	Continued From page 43 Entry Point (CEP). During the investigation the employee is supposed to be removed from the schedule pending investigation. SSD-A verified R23's allegation of abuse was reported on 8/14/13 after internal investigation was completed by nursing department. SSD-A stated that she submitted investigations when she was told to do so especially on complaints that she had not directly received. SSD-A further stated she what's to report more than she is being allowed to report from the previous administrator directions and she was educating staff on reporting to the SA immediately and not waiting for her. On 08/16/13, at 9:30 a.m. interviewed RN-A stated resident complaints were investigated immediately upon reporting all allegations to the staff who report it to management to follow up and decided if they needed to be called to the SA. On 8/16/13, at 1:11 p.m. interviewed O-G stated she went immediately to resident after surveyor had reported to facility about issue and started the investigation. O-G stated when she interviewed resident he stated "he just wanted the nursing assistant to stop treating him like his "Pa", he was okay with aide assisting him but just wanted the aide to respect him. She further stated after she had interviewed the resident "there was no urgency to report the issue to OHFC immediately as the resident did not think he had been abused but rather was a cultural issue going on." Surveyor asked O-G if "cultural issue " was specified in the abuse policy but SSD-A around at the time responded that this was treated differently due to the issue of culture and verified facility policy had no mention of culture and that all reports or allegations of abuse, neglect and maltreatment are treated the	F 225		

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F 225	Continued From page 44 same. Ecumen's Abuse Prevention Plan for Minnesota Skilled Nursing facilities dated 06/06/13 directed "Immediately* conducting a thorough investigation and documenting findings on the Incident Form(s) and Resident(s) Medical Records. " The policy lacked directions that all alleged violations and all substantiated incidents were to be reported to the State Agency and that the facility was to analyze the occurrences to determine what changes are needed, if any to policies and procedures to prevent further occurrences. The facility failed to investigate why the same nursing assistant had issues with residents that she assisted and analyze the cause accordingly. Additionally the policy used state language and not federal terms.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a policy that included resident to resident abuse, reporting elopements and implementing the policy on reporting timely to the State Agency (SA) for 2 of 2 residents (R41, R8) with resident to resident altercations, 7 of 7 (R599, R598, R85, R597, R89, R55, R595) for elopement and 2 of 2	F 226		

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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 226	Continued From page 45 residents (R56, R87) with bruises of unknown origin. This had the potential to affect all 66 residents residing in the facility. Findings include: Review of facility policy titled, "Ecumen's Abuse Prevention Plan for Minnesota Skilled Nursing Facilities dated 06/06/13, lacked evidence of direction for resident to resident altercations and for elopement. In addition, the policy directed "This facility has an internal reporting system for suspected maltreatment. A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately report the information to the director of nursing (DON). If the DON is absent, it shall be reported to the DON's designee and if no designee then the facility nursing supervisor. The facility professional who receives the report of suspected maltreatment is then responsible for immediately reporting the maltreatment to the facility Administrator or the Administrator's designee, the Minnesota Department of Health and the common entry point (CEP) as decided in this section." On 8/12/13, at 7:55 p.m. a request for all of the reported and non-reported Vulnerable Adult forms was made to the facility administrator, DON and social service designee (SSD), as abuse had been identified during the stage one survey by all four surveyors. The DON stated they would have the files available for review in the morning, and she was not surprised by the request. On 8/14/13, at 6:23 p.m. the particulars with the	F 226	**F 226** 1. Corrective Action: A) Resident #41, 81, 8, 82, 1, 87, 13, 18, 56 and 23 had their Incident Report and/or chart reviewed by an RN. Care plans were updated accordingly. B) Resident #18 had her incident from 5/13 related to the medication cart and her foot reported to the State Agency/CEP on 8/12/13. C) Resident #23 had his incident related to the allegation of staff abuse reported to the State Agency/CEP on 8/14/13. D) Residents #55, 85, 89, 595, 597, 598 and 599 are no longer residents of St. Olaf's facility. E) Resident #45 has a new wander guard device and it is placed in the proper area of his w/c. His care plan reflects the use of the wander guard. 2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by these deficient practices.	

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F 226	Continued From page 46 abuse policy were reviewed with the administrator and DON. The policy lacked a statement of resident to resident altercations or elopements as potential abuse or neglect and reportable events. The facility policy contained an Appendix (B) that contained signs and symptoms of abuse and neglect. The facility failed to operationalize the abuse and neglect policy, report events that the policy or appendix identified as abuse or neglect and failed to report incidents of abuse or elopement to the SA. The administrator stated the policy was an Ecumen corporate policy and they would need to have corporate make any changes to the policy. R41 was identified by the facility as having sexually inappropriate behaviors, R41 and R81 were found by facility staff during a sexual encounter on 6/1/13; the incident was not immediately reported to the administrator, immediately reported to the State agency and was not thoroughly investigated to rule out potential resident to resident mistreatment. On 6/1/13, at 6:30 p.m. R41's Nurse's Notes indicated, "Resident [R41] was witnessed in his room engaging in a sexual act with another resident [R81], when door opened, this resident stated 'Get out, Respect our privacy'! [sic]" The note indicated the weekend supervisor, the social service designee (SSD) and nurse practitioner were notified via telephone, or had a voice message left for them. On 6/2/13, at 1:00 p.m. a Nurse's Notes indicated R41 had "no sexually inappropriate behavior" noted. A note at 5:00 p.m. indicated R41's conservator was called and updated on the 6/1/13 incident.	F 226	B) The Wander Guard System policy has been revised to include how to check that the device and system are functioning. C) The Missing Resident policy was reviewed. D) The Abuse Prevention Plan has been revised to include immediate reporting language and reporting of elopements. E) A Resident to Resident Altercation policy has been added to abuse prevention plan. F) Staff and Resident Council were educated that all residents must sign out and sign back in when they leave the facility. G) All facility staff has been educated on the revised Wander Guard policy, the Abuse Prevention Plan, the Incident Reporting policy, the Missing Resident Policy and resident sign out book at reception desk.. 3. Date of Completion: 10/3/13 4. Reoccurrence will be Prevented by:	

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F 226	Continued From page 47 Although the clinical record indicated R41 was monitored for sexual activity and behaviors after the incident on 6/1/13, the clinical record lacked evidence the administrator and State Agency (SA) were notified immediately and lacked evidence the incident was investigated to determine if the sexual contact was consensual between both residents. On 8/19/13, at 11:32 a.m. the director of nursing (DON), registered nurse manager (RN)-A, and RN nurse consultant were notified of the Nurse's Notes on 6/1/13, which indicated R41 was found having a sexual encounter with another resident. The DON stated she believed she "may be" aware of whom (the other resident was), but was unclear. Information regarding the incident was requested. The RN nurse consultant checked the "Fall Tracking" log and stated the incident was not recorded there. On 8/19/13, at 2:12 p.m. the surveyor, DON and SSD met regarding R41's 6/1/13 incident. The DON verified R41 was found by facility staff to be engaging in a sexual act with R81 in R41's room. The SSD and DON stated when staff discovered R81 with R41, the residents requested privacy, they were left alone in the room, the nurse supervisor was notified and the SSD was called. The DON and SSD stated both of the residents' guardians and family were contacted; nurse practitioners (NPs) for both were updated. Both the DON and SSD stated R41 was alert and oriented and able to make "that choice" and stated R81 had a mental illness, R81's BIMS was "15 [even though the last BIMS indicated a lower score and moderate impairment]." Both stated although R81 had a mental illness, R81 was able	F 226	B) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. The Correction will be Monitored by: B) Director of Nursing or Designee	

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F 226	Continued From page 48 to "state no or consent." Both staff stated R41's guardian was okay with the contact and R81's guardian referred the question to R81's mental health worker. The SSD stated the mental health worker was more familiar with R81 having worked with R81 "through the commitment process." DON stated R81 was identified to have a "long history of sexual activity." Both verified no incident report was completed regarding the incident. The DON stated R41's diagnosis of genital herpes was "latent" and it was unclear if he was actually having problems as he completed his own cares and staff did not observe his genitalia. The DON stated the facility was ordering a HSV test (a test for genital herpes) for R81. The SSD stated she called and notified the administrator as soon as she received the voicemail and was aware of the incident, but was unclear when that was. The DON and SSD both confirmed no investigation was completed after the administrator was notified and verified at no time was the SA contacted. Although the incident was not investigated to determine resident consent, both felt the incident was not reportable due to both residents being "consensual." R8's Resident Admission Record dated 1/10/08, indicated R8 had diagnoses of adjustment disorder with depression, anxiety, convulsions, muscle spasm, infantile palsy, stroke with hemiplegia (loss or decreased use of one side of the body), contracture, dystonia (lack of muscle control), and narcissistic personality disorder with anti-social traits. The resident had a plan for extreme verbal and physical abuse that included, to be removed from the facility by a call to 911 to send resident to the Hennepin County Medical Center (HCMC) crisis intervention unit. The facility lacked a behavior management plan and/or behavioral programing	F 226		

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F 226	Continued From page 49 for R8 to prevent repeated verbal and physical abuse to staff and peers. R8's care plan initiated 9/29/08, indicated vulnerable adult at risk for harm to self or others, inappropriate behavior and altered mood state related to nursing home placement, anger with staff, verbally abusive/name calling, refusing cares, disruptive behaviors in common areas, swearing and yelling in dining room, physically arguing with staff and others. R8 was noted to be very impulsive and easily angered by other residents, verbally abusive and resistive with cares, received anti-psychotic, anti-depressant, and anti-anxiety medication as needed. The care plan indicated R8 had the tendency to perseverate on medical concerns, his eye glasses, etc. Interventions listed were to offer choices, remind him name calling was not appropriate or acceptable, attempt re-direction, and re-enforce his capabilities and competencies. Remove him to his room to calm down as needed, set limits with, leave him to cool off when he was verbally aggressive and check back. remind him to speak softer, call 911 and send to crisis (intervention unit when needed). Leave more space between tables in the dining room and fellowship hall, discuss keeping the peace, listen to concerns, express appreciation for efforts to be a gentleman, re-enforce positive outcomes. Discuss his role as on advocate throughout his life; discuss how others have positively impacted his life (wife who passed away). Kill with kindness approach, psychology following as needed, encourage him to do his puzzles. Inform resident's sister of behaviors. Complete vulnerability assessment per policy; continue to post abuse reporting form with staff and Hennepin Counties number. All staff [are]	F 226		

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F 226	Continued From page 50 annually trained on abuse reporting. The care plan included reporting abuse to Hennepin County but lacked direction to report to the SA. The significant change Minimum Data Set (MDS) dated 6/7/13, revealed a Brief Interview for Mental Status (BIMS) score of 11/15, which indicated moderate cognitive impairment and included evidence of delirium - psychomotor retardation that comes and goes. R8 required extensive assistance and two person physical assist with bed mobility and transfers, extensive assistance of one person for dressing, personal hygiene, toileting, and locomotion off the unit, and was independent in locomotion on the unit. The MDS indicated R8 had verbal behaviors directed towards others one to three days and physical behaviors one to three days in the look back period. The Care Area Assessment (CAAs) triggered behavioral symptoms, which was not addressed in the CAAs narrative summary. The incident reports for R8 were reviewed from 8/27/12, going forward and the following was noted: - On 8/27/12, during an altercation over the television (TV) in the third floor dining room, R8 struck R78 on the hand leaving a 3.0 centimeter (cm) by 1.5 cm bruise. R78 stated he "was watching a TV program at 7:00 p.m. and [R8] came into the dining room and wanted to watch TV, I told him I was already watching a program and would change it at commercial time, he [R8] started yelling at me so I tried to go back to my room, but he hit me on my hand!." R78 returned to his room and at 10:30 p.m. reported to the floor nurse that R8 had struck him. The report to the SA on 8/28/12 (one day late), indicated a registered nurse (RN) responded to yelling in the	F 226		

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F 226	Continued From page 51 dining room and saw a nursing assistant (NA) prevent R8 from charging R78. The investigative report was submitted 8/30/12, and noted R8 stated "I got so mad that I just hit him!." The report indicated R8 had a history of physically aggressive behavior towards staff and other residents at the nursing home. R8 had both in house psychologist on an as needed basis and a psychiatrist in the community. Staff followed the care plan, they are to protect residents and themselves, move other residents away from R8 to safety and call 911 to send R8 to HCMC crisis unit if R8 was non re-directable. The SSD had also spoken with the primary doctor (MD) regarding alternative placement in the community that would better suit R8's behaviors. The SSD will make a referral for relocation services for a more appropriate environment. - On 9/9/12, (un-timed) R599 reported to staff that R599 attempted to help another resident pick something off the floor on ground level. R8 asked R599 to move out of his way. When R599 did not move fast enough, R8 became mad and elbowed R599 in the arm and attempted to push him out of the way. The incident was reported to the SA on 9/10/12 (one day late). The investigative report submitted 9/13/12, indicated care plan interventions were followed for both verbal aggressive behaviors and physical behaviors. Residents were immediately separated and R8 was asked to lower his voice. R8 had other incidents at the facility. "(A) 911 protocol is in place for R8, staff was aware to contact 911 and send R8 to HCMC crisis unit if behaviors are unmanageable." The SSD was in the process of requesting Hennepin County relocation services to assess to see if R8 was appropriate for a group home setting. R8 was also seen by the in house psychologist on 9/10/12, for behavior	F 226		

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F 226	Continued From page 52 management. On 12/31/12, MDH report at 8:00 p.m. revealed "R8 did not agree with other residents in the dining room that the TV channel should be changed and verbally threatened R76, another resident on 3rd floor that was present in the dining room. The incident was reported to the SA on 1/1/13 (one day late). On 8/12/13, at 1:00 p.m. R8 requested an interview with surveyor, and stated his name was being slandered by a resident that said he had abused her. R8 was sitting at a dining room table watching a movie, with his puzzle books and mail on the table. The ombudsman name and phone number was provided to R8. On 8/12/13, at 8:00 p.m. R8 was observed to have a verbal outburst at the peer he said was slandering him, and became agitated, leaning forward repeatedly in his wheelchair, towards the peer, staff intervened and attempted to redirect the resident who continued his verbal outburst. R8 was again at a third floor dining room table watching a movie with his puzzle book nearby. On 8/14/13, at 6:00 p.m. R8 was observed to have a verbal outburst in the dining room on the third floor, during the dinner meal. The staff was not able to redirect R8 and the DON had to intervene to calm R8. On 8/16/13, at 8:43 a.m. the SSD stated she was not aware of the physician comment that this was not the appropriate setting for R8, and stated she had been attempting to get ammunition to get a 30 day discharge. The SSD stated she had requested a behavioral management plan for R8	F 226		

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F 226	Continued From page 53 and was told to move the other residents out of the dining room, but the other residents refuse to go, because they are not doing anything wrong. The SSD stated that R8 is very territorial and had refused to watch the TV in his room. The SSD was not aware that R8's care plan did not address physical aggression other than the call to 911 to remove R8 from the facility. The SSD further stated that when R8 acts out and she had restricted him to his room, she will come back into the facility and find R8 in the dining room, because the plan (written in the communication book) had not been followed by staff. The SSD further stated R8's behaviors dissipated when he was ill in May and June 2013 and the facility had attempted to find other placement for him, but he refused and stated he wanted to be here and the family wants him here and participate in care conferences, but say "how can he get away with this behavior." The psychologist ' s recommendation was to remove others from the environment, but they refuse since they are not misbehaving. When 9-1-1 was called, they do not always take him out to HCMC; if he refuses they leave him here. On 8/12/13, at 5:20 p.m. the administrator, DON, SSD, and RN nurse were in the DON office and verified that R8 had had an altercation, yelled at and struck R78, the abuse was reported on 8/24/13, and was then reported to Hennepin County and the State agency (SA), in addition they also verified the statement of R78 that the perpetrator (R8) had "verbally and physically attacked" other people and had been "crisised out of the building" (by calling 9-1-1) several times, received inpatient psychiatric stays and medication changes, and had been allowed back into the facility.	F 226		

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F 226	Continued From page 54 R599's Resident Admission Record dated 8/20/12, noted R599 had diagnoses of persistent mental disorder, altered mental status, diabetes, a right below the knee amputation, gait abnormality, and active drug abuse. The care plan dated 9/19/12, indicated R599 required assistance of staff to stabilize during transition from sitting to ambulation or for transfers. R599 left the facility (elopement) without orders or medications during the week of 11/23/12, according to the Report of Suspected Abuse or Neglect of Vulnerable Adults form. R599 was hospitalized (at an unknown date and time) secondary to no medications. On 1/3/13, the elopement was reported to Hennepin County as "against medical advice discharge after 41 days." It was unclear what day the resident left the building. The elopement was not reported to the SA for eight months. The facility did not report the elopement after the surveyor intervened. R598's Resident Admission record dated 7/24/12, noted 598 to have diagnoses of liver cirrhosis with ascites (enlarged liver with fluid backup into the abdomen), a history of heart bypass surgery, congestive heart failure (fluid backup into the feet and legs) and diabetes. The care plan dated 8/1/12, noted R598 had a risk of falls due to loss of balance during transitions. R598 had verbally abusive behavioral symptoms, and had threatened and screamed at	F 226		

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F 226	Continued From page 55 others. R598 left the facility (elopement), without orders on 1/3/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. R598 left in the company of his daughter stating "get me the (profanity) out of here." R598 did not return to the facility. The facility did not report the elopement to the SA. R85 was admitted on 8/14/12, with admission data base diagnoses of chronic kidney disease, hypertension, learning difficulty, homelessness, socially inappropriate and disruptive behavior. The MDS dated 2/19/13, indicated R85 was cognitively intact and independent in all activities of daily living. The care plan updated 8/5/13, indicated a self-care deficit, socially inappropriate behavior in the dining room (yelled and threw things), and resisted cares and medications. R85 left the building without signing out (elopement) during the evening on 1/8/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. It was unclear when the administrator was notified (un-timed). It was unclear when it was reported to Hennepin County (un-timed) and a statement was added to say the resident returned to the facility on 1/9/13, at 7:00 p.m. Hennepin County was updated on 1/10/13. There was no indication of a police report of a missing person report being filed. The facility did not report the elopement to the SA.	F 226		

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F 226	Continued From page 56 R597's Resident Admission Record noted 597 to have diagnoses which included multiple rib fractures from a fall, congestive heart failure (fluid backup into the lungs), chronic obstructive pulmonary disease (lung disease), diabetes, and depression. No assessments were completed for R597. An admission care plan dated 1/28/13, indicated R597 used a cane to ambulate. R597 left the facility, "stating he did not want to stay" (elopement) on 1/30/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. The facility did not report the elopement to the SA. R89's MDS dated 2/20/13, indicated moderately impaired cognitive skills for daily decision making-decisions poor, cues/supervision required. R89 required extensive assist of two with bed mobility and transfers, extensive assist of one for dressing, personal hygiene and toilet use. A care plan for R89 was requested and not provided. R89 left the facility on 2/25/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. R89 left with his family (elopement) after being told there were no orders for a leave of absence, he did not return to the facility. That was reported to the director of nursing (DON) on 2/25/13. The facility did not report the elopement to the SA.	F 226		

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F 226	Continued From page 57 R55 left the facility twice without supervision. The MDS dated 4/24/13, indicated intact cognition. R55 required assist of one with bed mobility, dressing and toilet use, supervision with transfers, and set up for personal hygiene. R55 required assist of one with bed mobility, dressing and toilet use, supervision with transfers, and set up for personal hygiene. The Brief Interview for Mental Status (BIMS) 4/24/13, indicated a BIMS score of 15/15 - which depicted intact cognition. On 4/25/13, at 11:00 a.m. R55 signed out of the building but did not return (first elopement). On 4/26/13, at 8:00 a.m. a Report of Suspected Abuse or Neglect of Vulnerable Adult form was filled out. Hennepin County was notified on 4/26/13, at 8:33 a.m. the medical doctor (MD) was notified (un-timed) and gave parameters if resident not back in 24 hours to do an against medical advice discharge. Police were notified (undated and un-timed). On 4/26/13, "in the evening hours" (un-timed) the resident returned to the facility and Hennepin County and Police were notified of the return. The elopement was not reported to the SA. On 5/6/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form, R55 left the facility without supervision, and did not return (second elopement). Hennepin County was notified on 5/7/13, at 2:08 p.m. a report to the police (undated and un-timed) was attached to the form. On 5/7/13, at 11:34 p.m. the resident returned to the facility. The elopement was not reported to the SA.	F 226		

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 226	Continued From page 58 R595's Resident Admission Record dated 5/31/13, R595 was noted to have diagnoses which included bi-polar adjustment disorder (mental illness). No assessments were completed. R595 stated they were going for a walk and did not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. Hennepin County was notified on 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not reported to the SA. Documentation for R595 was requested and not provided. On 8/16/13, at 8:43 a.m. the SSD (the person identified for abuse concerns) stated staff would report immediately to administrator, the DON, SSD, Hennepin County and the SA. If there was an allegation of abuse, staff were removed until the investigation was completed, and then the results of the investigation were reported to administrator, Hennepin County and SA. When the late reporting was discussed, the SSD did state that she had created and provided education on how to report for the staff, but she continued to work with them on timely reporting since the staff wait for her to report. The SSD further stated that she had been directed by prior administration not to report the above cases to the SA, even though she questioned the situations. The SSD had been working on improvement of the abuse tracking log and the grievance log. The SSD further stated that the	F 226		

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F 226	Continued From page 59 DON investigated complaints against the staff and the SSD investigated the others, such as resident to resident altercations. All allegations of sexual abuse, corporal punishment, etc. would be investigated. When asked why the resident to resident altercations and elopement were not in the policy, the SSD stated that's a corporate policy you'll need to speak to the administrator and DON. Bruises of unknown origin: R56's MDS dated 4/24/13, indicated moderate cognitive impairment with inattention and disorganized thinking. R56 required extensive assistance of one with bed mobility, transfers, eating, dressing, grooming, personal cares, and toileting. The CAA summary indicated R56 had behavioral symptoms of resistive and combative to cares. R56 was noted to have bruises on his shoulders that appeared to be in the shape of fingerprints on 6/18/13. Six staff members were interviewed and education was provided to three staff on proper repositioning techniques. The injury was determined "most likely from assisting with positioning during cares." The diagram on the incident report indicated bruises on the on the shoulder, above the arm pits bilaterally. The injury was not reported to the SA. R87 was observed on all days of the survey to be sitting and walking with R82. The facility failed to investigate and report bruises for R87 who had bruises of unknown origin. During observation on 8/12/13, at 5:42 p.m. R87 was noted to have dark purple bruising on the knuckles of the left hand and dark purple bruising to the right wrist area. When asked, R87 reported	F 226		

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F 226	Continued From page 60 she fell down the stairs. During observation on 8/15/13, at 9:16 a.m. R87 continued to have the bruising to the left knuckles and the right wrist and another 7 centimeter (cm) x 4 cm dark purple was noted to R87's left forearm. On 8/19/13, at 10:06 a.m. R87 was observed to have a dark purple, thumb sized bruise on her left inner forearm. R87's care plan dated 12/13/12, identified her as being at risk for harm from self or others related to a diagnosis of dementia. The care plan does not identify risk for bruising or bleeding. In addition R87's care plan indicated she was resistive to cares with an approach to include "When resident begins to resist care, STOP and try task later. Do not force to do task." The admission MDS dated 12/18/12, indicated R87 had both short and long term memory problems and moderately impaired cognitive skills for daily decision making. A Resident Incident Report dated 3/27/13, noted a 4 cm x 5 cm bruise to R87's outer left hand. The immediate interventions were noted as monitor and redirect and requested Geri-sleeves from the nurse practitioner. RN assessment indicated trial of Geri-sleeves was unsuccessful and to monitor areas and encourage resident not to grab hands, just hold hands. A Resident Incident Report dated 6/14/13, 7:00 a.m. indicated R87 was noted to have a 1.5 cm x 2.5 cm bruise on the left wrist. Interventions noted to monitor skin daily and monitor for and redirect when residents holding arms/wrists to hold	F 226		

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F 226	Continued From page 61 hands. Nurse's Notes were reviewed from 4/13 forward and the following was noted: - On 4/29/13, indicated more bruises noted to body, blue and yellow in color. The last Resident Incident Report was dated 3/27/13. - On 7/6/13, noted multiple bruises on both (unidentified area) remained. - On 7/20/13, indicated R87 had old bruises on both lower arms. Review of the Resident Incident Reports and the Nurse's Progress notes revealed no documentation regarding these bruises. A Physician's Order dated 7/29/13, directed to monitor skin every shift and document new areas in the nurses notes. R82's Behavior/Intervention Monthly Flow Record for August 2013, noted R82 was monitored for "abusive to others" which was noted as occurring two to three days on day shift from 8/7 to 8/12/13. When interviewed on 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. During an interview on 8/16/13, at 11:11 a.m. the nurse consultant (O)-D stated bruises are tracked on incident reports. On 8/19/13, at 2:09 p.m. the director of nursing was again asked for documentation regarding assessment and intervention for R87's bruises noted throughout the survey and none was provided. A policy regarding ongoing monitoring of	F 226		

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F 226	Continued From page 62 resident's skin condition was requested but no policy was provided.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote the dignity of 1 of 1 resident (R68) related to failure to provide dignified continence care, and failure to ensure the resident had appropriate fitting clean clothes and equipment. Findings include: R68's personal cares were observed on 8/14/13, at 8:30 a.m. provided by a nursing assistant (NA)-B. Without asking the resident, the NA assisted the resident to don a pair of very ill-fitting pants that were loose around the waist. The NA stated she just noticed the pants did not belong to R68, as they were labeled with another resident's name and room number. She removed the pants and obtained another pair of pants from the resident's closet that were too short and small around the waist, and could not be buttoned or zipped. NA-B reported there were no other pants in R68's closet. The resident left the room with his pants partially unzipped and unbuttoned. NA-B did not state whether the shortage of clothing had been reported to a nurse or social service	F 241		

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F 241	Continued From page 63 designee. An interview with dialysis program registered nurse (DPRN)-B was completed on 8/14/13, at 1:20 p.m. The RN reported R68 regularly attended dialysis and was generally quite compliant with their expectations. The RN said he did have concerns regarding the resident's personal hygiene and unkempt appearance, and dirty clothing. There had also been incidents where the resident had been incontinent of stool and there was feces on the resident's walker. When concerns were noted with R68's personal hygiene, they always reported the issue to the licensed practical nurse (LPN)-D. An interview was conducted with DPRN-A on 8/14/13, at 1:45 p.m. The RN stated she had received reports from the transportation staff of R68 being incontinent both when he was picked up for his appointment, as well as in the vehicle on the way to dialysis. She was aware of the resident had dried feces on his walker, but said she had noticed that recently the resident's personal care seemed to have improved. The RN stated R68 reported he "hates living at the facility." An interview was completed with an outside provider transportation staff (TS)-A on 8/15/13, at 12:30 p.m. In a very loud and angered voice, the TS reported that approximately four months prior, he had picked up R68 for an appointment, and the resident was not waiting for him in the entryway. The driver went unescorted to the resident's room. While walking toward R68's room he overheard a nursing staff and a housekeeping staff "yelling" at each other in a verbal disagreement over who was responsible	F 241	**F241** 1. Corrective Action: A) The Conservator for Resident #68 was contacted and has provided him with properly fitting clothing. 2. Corrective Action as it applies to other residents: A) All residents have the potential to be affected by this deficient practice. B) All residents clothing needs have been evaluated and clothing obtained as necessary. C) Nursing staff was educated on the expectation that residents will be clean and appropriately dressed at all times. D) The Care Conference Summary form was revised to remind the IDT to question resident clothing needs at least quarterly. E) Nursing staff was educated to contact the Social Service Director whenever the resident has clothing needs so she can contact the	

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F 241	Continued From page 64 for cleaning up R68's bathroom, as there was feces everywhere. TS-A entered the resident's room and observed feces all over the bathroom wall and floor, as well as on the bedroom floor. Although the housekeeper and housekeeping supervisor observed TS-A enter the room, they acknowledged they did not attempt to stop him. R68 was observed lying in bed in feces with "nothing on other than a diaper." He (TS-A) reported there was no linen on the bed to cover the resident. TS-A also observed a bag of soiled clothing that had evidence of urine and stool. The driver found an unidentified nursing staff and informed the staff the resident needed to be assisted to get ready for an appointment. The staff person said he would have to wait, "as the resident had no clean clothing available." TS-A acknowledged opening the resident's closet and saw it contained four pair of pants and six shirts. TS-A reported there were other occasions when he picked up the resident of an appointment to find he had feces on his clothing and walker. Because he no longer transported the resident to appointments, he was unaware of further incidents. TS-A stated he reported the incident to the social service designee at the dialysis unit, and stated he was "appalled at what I witnessed." An interview was conducted on 8/15/13, at 2:33 p.m. with a LPN-D. The LPN reported that at times R68 had been uncooperative and there were incidents when the resident went to dialysis with evidence of stool incontinence and in dirty clothing. She reported she had heard about these incidents in the change of shift nursing report. LPN-D denies receiving any reports or phone calls from any staff at the dialysis program regarding any concerns regarding his personal hygiene, reports of incontinence or not being	F 241	responsible party with the request. 3. Date of Completion: 10/3/2013 4. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. The Correction will be Monitored by: A) Director of Nursing or Social Service Director or their designee's	

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F 241	Continued From page 65 appropriately attired. On 8/16/13, at 8:31 a.m. R68 was alone in his room. He was dressed in a polo shirt with a hospital gown draped over his legs. NA-J entered the room with the same pair of pants that R68 wore on 8/14/13. The NA explained the resident had no clean pants in his closet, so she had gone to the laundry to find some clothes. The resident was assisted to don the pants, which were again too small and could not fully be zipped. An interview with R68 was completed on 8/16/13, at 2:15 p.m. He stated he did not recall being dressed in ill-fitting clothing. He denied episodes of incontinence or resisting care. He said he did not like living at the facility and wished to live with his children. On 8/19/13, at 9:25 a.m. the resident was observed sitting on the edge of the bed, wearing the same pants he wore on 8/14/13 and 8/16/13. R68 reported that his pants did not fit, which bothered him as he had to walk down the hallway in front of others with his pants unbuttoned and unzipped. He stated he needed more clothing, but he did not know who to talk to about it. He stated it bothered him that he did not have enough clothes. R68's significant change Minimum Data Set (MDS) dated 7/19/13, revealed the resident had moderately impaired short and long term memory problems. Although he exhibited periods of being inattentive and had disorganized thinking, he displayed no mood or behavioral concerns. He was cooperative with cares, and required extensive assistance of one staff with bed mobility, transfers, dressing, toilet use and	F 241		

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F 241	Continued From page 66 personal hygiene. The Care Area Assessments (CAAs), completed on 7/12/13, and indicated the staff had noted a decline in the resident's mobility and although some improvement was noted, the resident had declined overall and had variations in mobility due to his medical condition. He was frequently incontinent of bowel and bladder. The bowel and bladder plan of care dated 10/8/12, indicated R68 had occasional episodes of bowel incontinence at times when on certain medications when his dialysis labs are high. "This is not new for him and expected to continue to vary." An interview on 8/15/13, at 2:33 p.m. was completed with LPN-D, who reported at times R68 had been uncooperative and there had been incidents when the resident did go to the dialysis program with evidence of stool incontinence and in dirty clothing. She reported she had heard about these incidents in the change of shift nursing report. LPN-D denied ever receiving any reports or phone calls from any staff at the dialysis program regarding any concerns regarding his personal hygiene, reports of incontinence or not appropriately attired. On 8/19/13, at 10:06 a.m. NA-I was interviewed. NA-I acknowledged she had assisted R68 with his personal cares and the resident frequently did not have enough clothing, particularly pants, as "they are in the laundry." NA-I did not state whether she had reported it to a nurse or social service designee. On 8/19/13, at 4:41 p.m. the social services	F 241		

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F 241	Continued From page 67 designee-A was interviewed. She reported being unaware that R68 needed clothing until the end of that week, and said the clothing shortage should have been reported to her earlier. An interview with the director of nurses (DON) was completed on 8/19/13, at 5:10 p.m. She acknowledged it was unacceptable for the resident not to have clothes that fit and efforts needed to be made to get the resident more clothing. She also stated the resident should not have left the building when incontinent or with soiled clothing and equipment. The DON validated it was not acceptable for the nursing staff to leave the resident lying on his bed in his feces, uncovered and exposed, while staff decide who was going to clean his living area. A policy regarding resident dignity was requested of the DON on 8/19/13, at 5:10 p.m. however, no policy was received.	F 241		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically related social services to address repeated elopements from the facility for residents (R45, R599, R598, R85, R597, R89, R55, R595),	F 250		

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F 250	Continued From page 68 refusals of range of motion (ROM) for (R35), and failed to provide psychosocial services for behavioral needs including altercations for (R8). Additionally, the facility failed to provide social services regarding investigating bruises for (R56) accordingly. Findings include: R45's Resident Admission Record indicated the resident was admitted to the facility in 9/12 with diagnoses including dementia, persistent mental disorder, depressive disorder, and left hemiplegia. R45 was not provided with medically related social services to address repeated elopements from the facility on 7/1/3, 7/2/13, 7/11/13, 7/29/13 and 7/31/13. The annual Minimum Data Set (MDS) dated 9/25/12, indicated R45's Brief Interview of Mental Status (BIMS, used to determine cognition) score could not be completed and identified R45 had short and long-term memory impairments; R45 required physical assistance with all activities of daily living (ADLs). The staff assessment of Public health Questionnaire (PHQ)-9 (a tool used to identify potential depression/mood concerns) score was eight (low). The mood assessment indicated R45 had: little interest or pleasure in doing things; poor appetite or overeating; stated life "isn't worth living," and R45 "wishes for death, or attempts to harm self; R45 was described as short tempered 7-11 days (half or more of the time) during the assessment period. The MDS identified R45 displayed physical behavioral symptoms and rejection of cares daily. Wandering was not identified. The corresponding Care Area Assessments	F 250	**F. 250** 1. Corrective Action: A) Resident #45 has a new wander guard device and it is placed in the proper area of his w/c. His care plan reflects the use of the wander guard. B) Resident #45 had an assessment of his behavioral needs and his psychotropic medications now have specific target behaviors and indication for use. His care plan reflects the target behaviors and indications for use. C) The psychologist consult for resident #45 was reviewed and his care plan was updated to reflect the suggested interventions. D) Resident #45 was assessed for continued elopement risk and his care plan was updated to reflect his current needs related to this risk. E) Residents #55, 599, 598, 85, 597 and 595 are no longer residing at St. Olaf's. F) Resident #35 was assessed for splinting/brace needs and for ROM needs. His care plan was revised and now reflects what to do if he refuses splints/braces or ROM. G) The psychology consult of resident #35 was reviewed and	

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F 250	Continued From page 69 (CAAs) dated 9/25/12 identified cognitive loss and the inability to make independent decisions, inattention, disorganized thinking, physical behaviors towards others and rejection of cares. The resident had experienced "a difficult time adjusting to the move" and because of suicidal risk was referral to the psychiatrist. The social services designee (SSD) was to be available to assist the resident and family, and staff would "proceed with inappropriate behavior care plan." The CAA for Falls/Psychotropic Medication Use dated 10/2/12, revealed R45 "could be impulsive at times." A quarterly MDS dated 6/21/13, indicated R45 had a BIMS score of 10, showing moderate cognitive impairment, and no mood or behavior problems were identified. Resident Incident Reports (RIRs) from 1/13 to 7/13 and R45's nursing notes revealed the following: 1) R45 was found by the stairway on 1/6/13, at 5:55 a.m. Thirty minute checks and a Wanderguard (a security alarm system) were initiated. The resident had removed the stop sign and opened the doors. He was "told not to go near the door as he may fall down the steps." 2) R45 wheeled himself out of the building on 7/1/13, at 5:30 p.m. telling the receptionist, "I want to go outside and see the world." The nurse practitioner (NP) was paged and asked to revisit the need for a Wanderguard, and an order was received with plans to check on the resident's whereabouts every 30 minutes. 3) R45 went outside the building for "fresh air" without altering staff. A new Wanderguard was placed and 30 minute checks for the evening shift and then one our checks at other times. The device was placed on the resident's (w/c), as he refused to wear it.	F 250	the recommended interventions were added to the care plan. H) Resident #35 had his behavior care plan reviewed and revised. His psychotropic medications now have appropriate target behaviors and indications for use. I) Resident #8 had his care plan revised to reflect his behaviors and interventions to use when resident displays these behaviors. His care plan also contains interventions to use when he is aggressive toward other residents. J) Resident #56 had his care plan revised to reflect interventions to prevent bruising during cares and position changes. 2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by these deficient practices. B) The Abuse Prevention Plan was revised to include the need to report elopement from the facility and resident to resident altercations. C) All staff was educated on the Abuse Prevention Plan and ROM documentation. Splints and braces reviewed and	

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F 250	Continued From page 70 4) On 7/9/13, at 4:00 p.m. R45 attempted to leave the facility and the Wanderguard alerted the receptionist who summoned help from nursing staff. R45 was verbally aggressive, yelling at staff and attempts to redirect him were "ineffective." The resident continued to yell until someone accompanied him outside the building. A therapeutic recreation staff person was assigned to walk with R45 outside, and one hour checks were to continue. 5) R45 left the building setting off the alarm on 7/11/13 (time not noted). The receptionist unsuccessfully attempted to redirect the resident. A nursing staff "ran out and caught him going fast down driveway ramp." R45 was argumentative, but came in with the nurse. At 4:00 p.m. another note revealed the resident was attempting to leave and the receptionist alerted the staff who assisted him outdoors. In addition, the staff discussed scheduled walks with the resident and his need for staffs' assistance. Several unsafe factors were identified including resident speed and inability to avoid uneven terrain including the sidewalk. During the walk R45 talked and sang to all the people who passed, and was unable to understand non-verbal cues from strangers. The resident's judgment in his surroundings was described as "poor." 5) A NP note dated 712/13, indicated R45 attempted to leave the building for exercise over the last three days and now had a Wanderguard in place on his chair. The resident said the weather was nice and the porch was not an option due to the smoke. The NP noted the resident had little tolerance for waiting for anything, and had a low frustration tolerance by history and redirection was often ineffective. 6) Staff alerted to R45 leaving by Wanderguard on 7/18/13 (time not noted) and several staff had	F 250	updated on care plan and NAR sheets. 3. Date of Completion: 10/3/13 4. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. The Correction will be Monitored by: A) Director of Nursing or Social Services Director or their designee's.	

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F 250	Continued From page 71 to assist the resident with w/c mobility due to "increased fatigue." 7) On 7/24/13, at 7:30 p.m. a new Wanderguard was placed underneath the resident's w/c, however, reasons for this were not noted. 8) R45 went out unsupervised on 7/29/13, at 4:00 p.m. as reported by the receptionist. The resident stated he did not go to the road. Hourly checks were noted and a follow up indicated the Wanderguard was working and the NP wrote new orders. The resident denied leaving the building and "became upset...New Wanderguard put on his Lt [left] ankle." 9) On 7/30/13, at 4:00 p.m. a nursing note revealed the resident was "more agitated lately & wanting to leave the bldg. [building] & go around by himself...very resistant to redirection." The NP was present and prescribed Depakote (anticonvulsant commonly used as a mood stabilizer). 10) On 7/31/13, at 9:00 a.m. the resident again left the building and "...got stuck on the driveway blocked the incoming cars from entering." The incident was witnessed by licensed practical (LPN)-H and trained medication aide (TMA)-F and the resident was "yelling, uncooperative." Interventions were to replace the Wanderguard; Depakote was increased, and follow up with walking times for R45. The 24-Hour Follow Up dated 8/1/13, indicated, "Resident has responded well to program...Will be working w/ OT [with /occupational therapist], staff to take out @ [at] 10 AM & 2:30 [p.m.] as desires. NP to re-evaluate medication." A corresponding nursing note revealed the NP was notified about the incident and indicated R45 was yelling and "doesn't respond to redirection." An order had been obtained for the occupational therapist to work with the resident for "community safety when	F 250		

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F 250	Continued From page 72 outside." Potential behavioral concerns were identified on the Social Services Meeting/Assessment Update forms, however, new concerns such as suicidal ideation and entering unsafe areas of the facility were not addressed, and the clinical record lacked a comprehensive assessment including a root cause analysis to determine appropriate strategies for address the concerns. The forms indicated the social service designee would "monitor" R45, evidence of such monitoring was lacking in R45's record to support how this was accomplished. The Social Services Meeting/Assessment Update forms from 9/25/12 through 6/25/13, were as follows: 1) On 9/25/12, R45 displayed physical, verbal and sexually inappropriate behaviors, a diagnosis of depression and a history of suicidal ideation, and was being seen on an as needed basis by the house psychologist/psychiatrist. 2) On 1/8/13, the resident was found in the stairwell and was put on 30 minutes checks. R45 was noted, "1st attempt" and the plan was for the social service staff to continue to "monitor for safety." 3) The next note on 3/26/13, the notes indicated R45 enjoyed singing and it was "good" for redirecting R45. 4) Notes revealed on 6/25/13, that R45 had a history of verbal and physical behaviors and was not easily re-directed, but like to sing and was encouraged to sing a song when he became upset. Doctor's Order Sheets revealed Depakote orders on 7/19/13, at 125 milligrams (mg) twice daily for	F 250		

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F 250	Continued From page 73 anxiety, and was increased to 250 mg twice daily on 7/30/13. Review of the June, July and August 2013 Behavior/Intervention Monthly Flow Records indicated the following: - The June record identified target behavior for mood monitoring for the Prozac and Remeron (antidepressant) was to be completed. Although the behavior sections of the sheets were blank, the evening shift had documented no mood behaviors. The day and night shift documentation was blank. - The July record identified the target mood monitoring for Prozac was increased sadness and tearfulness. The target mood monitoring for Remeron was increased isolation. The clinical record lacked target behavior mood monitoring for the use of Depakote. - The August record included monitoring for Depakote was increased isolation, increased agitation/verbally abusive; target behavior monitoring for Remeron was "depression;" the target behavior for mood monitoring for Prozac was increased sadness and increased tearfulness. The mood monitoring did not include resident specific target mood/behavior monitoring to determine indications for the use of the medications. On 8/15/13, at 1:31 p.m. the registered nurse (RN)-A stated the diagnosis for Depakote was "anxiety" and verified target behaviors needed to be monitored for were not resident specific. RN-A was unclear on the indication for the use of Depakote. RN-A stated "agitation" was monitored for and explained the target behaviors being monitored for were the same as for Remeron/Prozac (both antidepressant	F 250		

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F 250	Continued From page 74 medications). Although the clinical record lacked evidence of behavioral monitoring and the clinical record lacked evidence R45's elopements were adequately assessed, care planned and resident specific interventions were developed to address R45's elopements from the facility, on 7/19/13, Depakote was added to R45's drug regimen. The clinical record lacked evidence clinically related social services were provided to address R45's mood/behavioral needs, such as ongoing target behavior/mood monitoring, analysis of the behavioral/mood data and development of the care plan. Although R45 was started on Depakote for "anxiety" the clinical record lacked strong evidence the medication was warranted and R45 was adequately assessed for the need of the medication. The Associate Clinic of Psychology progress notes indicated the following: - On 9/24/12, R45 was seen for a Diagnostic Assessment due to an incident when R45 was physically aggressive and "he swung and hit staff who were attempting to move/assist him in his w/c." The assessment indicated R45 had dysthymic disorder, adjustment disorder with disturbance of mood and conduct, obsessive compulsive personality traits and vascular dementia. The Impression/Treatment Plan Recommendations section of the assessment identified, "Difficulty hearing and comprehending staff instructions may be a precursor to escalating behavior and physical aggression." The assessment indicated, "I found today that showing interest, letting him know that staff are there to help him and too [sic] not become invasive of his personal space severed [sic] to	F 250		

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F 250	Continued From page 75 manage aggressive features." The recommendations included: staff should not take control of R45's w/c, as it was an "extension of his body," and directed to welcome R45 to propel himself to locations, gain permission to touch his w/c if needed for longer distances and to "assist while continuing to evaluate his agreement would be important." The plan directed to observe R45's daily routine preferences, write down key events and involvements to help R45 anticipate what was going to happen in the day, encourage R45 to sing barbershop quartet songs, play video games and "showing interest in these areas in likely to have a beneficial mood affect for him." - On 10/8/13, the progress note indicated R45 was being treated for "clinical depression." The note identified R45 was playing computer games and indicated, "Anger management and urging him to use pro-social channels of communication, i.e., putting his feelings into words, meeting with the nursing staff periodically and finding other expressive modalities, for example, through his music or his computer to feel better were primary treatment interventions addressed today." The Treatment Plan included the following: "3. [R45] will sing for 15 minutes per day and share his music with others who may be interested as this is associated with enhanced mood." "4. [R45] may benefit from use of one-minute program approach where team members see him, use upbeat greetings and allow him to share his music or an interest of the day for mood enhancement." - On 7/22/13, the progress note indicated R45 was seen for "psychotherapy follow up" and was treated for "anxiety disorder, obsessive compulsive disorder and history of boundary related problems, i.e., inappropriate touch or being undressed, i.e., in appropriate touch." The	F 250		

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F 250	Continued From page 76 note identified R45 was on a "facilitated walk program where staff accompanied him when possible on community walks." The Treatment Plan indicated the following: "1. [R45] may do well by allowing him to sing one of his barbershop quartet songs to staff in order to improve rapport, decrease anxiety and increase potential for compliance with cares." "2. [R45] indicates facilitated walks outdoors are mood enhancing and serve to decrease anxiousness. I conferred with social service who notes that he is on a facilitated walking program which should help curb anxious episodes." "3. [R45] does identify a sense of pride in his son adopting children and sharing his life values..." the plan included involving R45 in any "adaptive roles" at the facility to enhance his mood. Although the psychology notes identified resident specific interventions to enhance R45's mood, the clinical record lacked evidence the suggested interventions were implemented or attempted. Although the notes included the walking program, the clinical record lacked evidence the psychologist/psychiatrist was notified of R45's elopements on 7/1/13, 7/2/13 or on 7/11/13. The clinical record lacked evidence of ongoing social service assessment, which included integration of psychiatric service recommendations and behavioral concerns. The clinical record lacked evidence R45's elopements were identified as an ongoing safety concern which warranted immediate assessment and intervention. Although R45's primary physician was notified of the elopements from the facility, the clinical record lacked evidence R45's safety concerns were communicated to psychiatry/psychology. On 8/16/13, at 9:30 a.m. the SSD stated she was involved with the elopements when they were	F 250		

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"brought up" in the IDT (interdisciplinary team) meetings. SSD stated every time R45 had been out of the building, the receptionist called and R45 was able to be brought back into the building. SSD confirmed R45 had "gotten out." SSD stated the majority of the behavior problem was R45 wanted to go "now" such as in the middle of when staff were assisting other residents with eating. SSD stated the interim director of nursng (DON) sat down and created a walking program with R45, that R45 chose the times he was willing to go out and be escorted out of the building. SSD stated, "My involvement has been limited." SSD verified she completed the mood and behavior sections of the MDS and care plan. SSD confirmed the care plan did not address R45's elopements from the facility. SSD stated it was a team effort to address behaviors, but then stated, "[We] Currently have no behavior program here. It's being implemented. I need help on how to gather the information and then run with it."

On 8/19/13, at 10:05 a.m. the occupational therapist verified R45 was in therapy for "community involvement." The occupational therapist stated the treatment was to develop approaches with R45 while he was out on walks in the community. The occupational therapist stated R45 did not want staff to be with him and the nursing staff was "confused" on behavioral approaches with R45. The occupational therapist stated therapy staff provided teaching on how to talk to R45. The occupational therapist stated she went out with R45 on the walks, timed them and explained to R45 why staff was with him; encouraged R45 to choose times and for staff to not make R45 feel "isolated" as he was being escorted on these walks. The occupational

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therapist denied the therapy was to "prevent" potential elopements and stated the therapy was to assist with compliance with the walks around the block twice daily. Although occupational therapy had evaluated and assessed R45 for community involvement, the clinical record lacked evidence the behavioral approaches identified by occupational therapy were integrated into R45's behavioral care approaches and care plan.

R599's Resident Admission Record dated 8/20/12, noted R599 had diagnoses of persistent mental disorder, altered mental status, diabetes, a right below the knee amputation, gait abnormality, and active drug abuse.

The care plan dated 9/19/12, indicated R599 required assistance of staff to stabilize during transition from sitting to ambulation or for transfers.

R599 left the facility (elopement) without orders or medications during the week of 11/23/12, according to the Report of Suspected Abuse or Neglect of Vulnerable Adults form. R599 was hospitalized (at an unknown date and time) secondary to no medications.

On 1/3/13, the elopement was reported to Hennepin County as "against medical advice discharge after 41 days." It was unclear what day the resident left the building. The elopement was not reported to the State agency (SA) for eight months. The facility did not report the elopement after the surveyor intervened.

R598's Resident Admission record dated 7/24/12, noted 598 to have diagnoses of liver cirrhosis

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with ascities (enlarged liver with fluid backup into the abdomen), a history of heart bypass surgery, congestive heart failure (fluid backup into the feet and legs) and diabetes.

The care plan dated 8/1/12, noted R598 had a risk of falls due to loss of balance during transitions. R598 had verbally abusive behavioral symptoms, and had threatened and screamed at others.

R598 left the facility (elopement), without orders on 1/3/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. R598 left in the company of his daughter stating "get me the (profanity) out of here." R598 did not return to the facility. The facility did not report the elopement to the SA.

R85 was admitted on 8/14/12, with admission data base diagnoses of chronic kidney disease, hypertension, learning difficulty, homelessness, socially inappropriate and disruptive behavior.

The MDS dated 2/19/13, indicated R85 was cognitively intact and independent in all activities of daily living.

The care plan updated 8/5/13, indicated a self care deficit, socially inappropriate behavior in the dining room (yelled and threw things), and resisted cares and medications.

R85 left the building without signing out (elopement) during the evening on 1/8/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. It was unclear when the administrator was notified

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F 250	Continued From page 80 (un-timed). It was unclear when it was reported to Hennepin County (un-timed) and a statement was added to say the resident returned to the facility on 1/9/13, at 7:00 p.m. Hennepin County was updated on 1/10/13. There was no indication of a police report of a missing person report being filed. The facility did not report the elopement to the SA. R597's Resident Admission Record, noted 597 to have diagnoses which included multiple rib fractures from a fall, congestive heart failure (fluid backup into the lungs), chronic obstructive pulmonary disease (lung disease), diabetes, and depression. No assessments were completed for R597. An admission care plan dated 1/28/13, indicated R597 used a cane to ambulate. R597 left the facility, "stating he did not want to stay" (elopement) on 1/30/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. The facility did not report the elopement to the SA. R89's MDS dated 2/20/13, indicated moderately impaired cognitive skills for daily decision making-decisions poor, cues/supervision required. R89 required extensive assist of two with bed mobility and transfers, extensive assist of one for dressing, personal hygiene and toilet use. A care plan for R89 was requested and not provided.	F 250		

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F 250	Continued From page 81 R89 left the facility on 2/25/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form. R89 left with his family (elopement) after being told there were no orders for a leave of absence, he did not return to the facility. That was reported to the DON on 2/25/13. The facility did not report the elopement to the SA. R55 left the facility twice without supervision. The MDS dated 4/24/13, indicated intact cognition. R55 required assist of one with bed mobility, dressing and toilet use, supervision with transfers, and set up for personal hygiene. R55 required assist of one with bed mobility, dressing and toilet use, supervision with transfers, and set up for personal hygiene. The BIMS 4/24/13, indicated a BIMS score of 15/15 - which depicted intact cognition. On 4/25/13, at 11:00 a.m. R55 signed out of the building but did not return (first elopement). On 4/26/13, at 8:00 a.m. a Report of Suspected Abuse or Neglect of Vulnerable Adult form was filled out. Hennepin County was notified on 4/26/13, at 8:33 a.m. the MD was notified (un-timed) and gave parameters if resident not back in 24 hours to do an against medical advice discharge. Police were notified (undated and un-timed). On 4/26/13, "in the evening hours" (un-timed) the resident returned to the facility and Hennepin County and Police were notified of the return. The elopement was not reported to the SA.	F 250		

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F 250	Continued From page 82 On 5/6/13, according to the (un-timed) Report of Suspected Abuse or Neglect of Vulnerable Adult form, R55 left the facility without supervision, and did not return (second elopement). Hennepin County was notified on 5/7/13, at 2:08 p.m. a report to the police (undated and un-timed) was attached to the form. On 5/7/13, at 11:34 p.m. the resident returned to the facility. The elopement was not reported to the SA. R595's Resident Admission Record dated 5/31/13, R595 was noted to have diagnoses which included bi-polar adjustment disorder (mental illness). No assessments were completed. R595 stated they were going for a walk and did not return to the facility (elopement), according to the Report of Suspected Abuse or Neglect of Vulnerable Adult form which was dated Monday 6/3/13, at 8:00 a.m. Hennepin County was notified on 6/3/13, at 8:00 a.m. (three days after the elopement) and the police were notified (undated and un-timed). The elopement was not reported to the SA. Documentation for R595 was requested and not provided. ROM and splints: R35 was not provided medically related social services for refusals of range of motion (ROM) and refusals of his lower extremity leg splints/braces, foot braces, and the foot buddy for the w/c. On 8/12/13, 8/13/13, and on 8/14/13, R45 was	F 250		

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F 250	Continued From page 83	F 250		

observed to be without any orthotic devices. Review of the clinical record indicated R45 frequently refused the use of the ordered orthotic devices.

The Diagnoses Report - Clinical dated 3/31/11, indicated R35 had the following diagnosis: dementia, and depression with anxiety. The annual MDS assessment dated 2/13/13, indicated R35's BIMS score was 12, identified no changes with ADLs. The MDS identified impairment in both lower extremities. The MDS identified R35's PHQ-9 score was one (low potential for depression) due to feeling down, depressed, or hopeless two to six days (several days) during the assessment period. The MDS identified R35 had no behavioral concerns. The CAA for Falls/Psychotropic Medication use dated 2/27/13, identified R35 received an "antidepressant medication." The CAA indicated R35 received "Trazadone, Paxil & Wellbutrin for depression." The CAA indicated, "He is monitored for med [medication] side effects & observed for med effectiveness. His mood has been stable." The CAA identified R35's psychiatrist and psychologist and indicated, "No referrals are needed at this time."

The quarterly MDS dated 5/14/13, indicated R35 had a BIMS score of 13 (mild impairment). The MDS indicated R35's PHQ-9 score had improved and was now zero and indicated R35 had not behavior concerns.

The Physician's Orders dated 7/28/13, directed to apply knee splints to both legs. The splints were to be put on for one hour after breakfast and lunch; Ankle Splints both heel/elbow boots were to be applied starting at 2:00 p.m. thru the

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morning during sleep hours.
Range of Motion Program in morning and afternoon during the day and directed to complete the ROM program while in R35 was in bed.

The care plan for Alteration in mobility dated 3/15/10, indicated R35 had a "hamstring stretch program" daily, directed to set up for the program starting 10/4/10. A hand written update directed, "Bilateral leg splints on 1 hr [hour] after meals when in bed." [Undated] An update dated 7/16, "Refusing leg splints throws on floor." A note dated 6/12/13, "Pt [Patient] refuses leg gard" (leg guard on w/c behind foot pedals added 7/12. The care plan did not address the use of ankle splints. Although the care plan identified R45 refused the splints and threw them on the floor, the care plan lacked behavioral intervention strategies to address his refusals of care.

The undated Nursing Assistant Assignment Sheet AM/PM directed NA staff to apply R35's bilateral knee braces on as directed by the care plan, directed to complete "Hamstring stretch daily," to apply a "foot hugger plate" on the w/c. The sheet indicated, "Demanding - verbally abusive when care not provided when he wants it done." and, "Report non-compliance with cares to nurse."

An Associated Clinic of Psychology progress note dated 10/8/12, indicated R35 was being treated for "clinical depression" and, "Coping support, cognitive restructuring and socialization were primary treatment interventions addressed today." The Treatment Plan section indicated the following:
"1. [R35] is showing depressed mood with frustration and irritability." and identified R35 likes sports. The plan directed, "Care staff may wish to

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F 250	Continued From page 85 assist with channel selection, use of reminiscing particularly about outcomes of the games he is interested in. "2. [R35] may benefit in having some of the past newspaper clippings from the achieves of his hometown paper" and suggested family could be approached to assist with obtaining these, placing them in protective coverings as a "mood enhancement" by sharing them with residents, staff and others. "3. [R35] may benefit from follow-up restorative therapy exercises if not already attempted to help build strength and focus on his vitality." Although the psychologist made resident specific recommendations to address R35's mood and general wellbeing, the clinical record lacked evidence the above interventions were addressed or attempted. The care plan did not reflect the above recommendations. No further psychology visits were noted in the clinical record. Review of the Social Services Meeting/Assessment Update forms 11/20/12, through 5/21/13, indicated the following regarding R35's behaviors and refusals: - On 11/20/12, the notes identified R35 was "alert & oriented to person/place" and R35 was "unable to make independent decisions. Res cont. [continues] @ times to be very impulsive." R35 was identified as seen by the house psychiatrist and psychologist on an as needed basis. - On 2/28/13, the notes identified R35 "makes poor decisions re: his plan of care." The notes identified a history of behaviors and referred to the behavior care plan. R35's mood was identified as "stable" and he had "no signs/symptoms of depression - SS [social services] will cont. to monitor for signs/symptoms of depression." The notes indicated R35 was seen by the house	F 250		

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F 250	Continued From page 86 psychiatrist and psychologist on an as needed basis. - On 5/22/12, the notes identified R35 had "no changes in behavior or mood - SS will cont. to monitor." The notes indicated R35 was seen by the house psychiatrist and psychologist on an as needed basis. - On 8/14/12, the notes referred to R35's "behavior care plan" and, "No sign changes in behaviors" and "No signs/symptoms of depression. SS will cont. to monitor." The notes indicated R35 was seen by the house psychiatrist and psychologist on an as needed basis. - On 2/19/13, the notes indicated, "Res. continues to @ times [to] refuse cares but no significant behaviors in the last quarter. SS/Staff will cont. to monitor. Mood is stable. No signs/symptoms of depression." The notes indicated R35 was seen by the house psychiatrist and psychologist on an as needed basis. - On 5/21/13, the notes indicated, "Res has a hx [history] of refusing cares. No sign. changes in behaviors in the last quarter. Res [resident] is seen on PRN [as needed] basis by house psychiatrist/psychologist. Mood is stable. SS/Staff will cont. to monitor for signs/symptoms of depression." Although the Social Services Meeting/Assessment Update forms were completed regularly, the forms did not identify refusals of care, such as wearing orthotic devices, grooming or range of motion. The clinical documentation recapitulated R35 was "stable," had "No signs/symptoms of depression," was seen by "house psychiatrist and psychologist on an as needed basis," and further recapitulated "SS will cont. to monitor;" the clinical record lacked evidence R35 was monitored by social services, lacked evidence of analysis of R35's mood/behavioral data and lacked evidence of	F 250		

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F 250	Continued From page 87 root cause analysis and assessment of R35's behavioral concerns, such as refusal or rejection of care. In addition, the clinical record lacked evidence outside service recommendations, such as psychiatry/psychology recommendations and/or therapy recommendations, were followed up on and integrated into R35's care plan. The Behavior/Intervention Monthly Flow Records for August, June, and July 2013 indicated the following: - The record for June directed licensed staff to monitor for "depression symptoms" with intervention of "Refer to S.W. [social service designee]" for the use of Paxil. The month of June documentation was all "0's." Although a second monitoring record for Trazodone was blank for the mood behaviors to be monitored for, "0's" were documented 13 times during the evening shift and twice on the night shift. The clinical record lacked evidence of mood monitoring for the use of Wellbutrin SR. - The record for July directed licensed staff to monitor for "Depression" with intervention of "Refer to S.W." for the use of Paxil. The month of July documentation was all "0's." Two more monitoring records for Trazodone and Wellbutrin SR were included with the monitoring, but were both blank. The clinical record lacked evidence R35 was monitored for sleep in July. - The record for August directed licensed staff to, "Document # [number of] hrs sleep" for Trazodone. The documentation was of "0's" for the partial month of August and the number of hours R35 slept was not documented. Two monitoring records for Wellbutrin SR and Paxil directed licensed staff to monitor for "S/S [signs and symptoms of] Depression." The documentation was all "0's" for the partial month	F 250		

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F 250	Continued From page 88 of August. The Behavior/Intervention Monthly Flow Records lacked monitoring for resident specific depression symptoms, such as but not limited to irritable mood or refusal/rejection of care. The records indicated R35 was not consistently monitored for efficacy of Trazodone for sleep. In addition, the clinical record lacked evidence R35 was comprehensively assessed to determine monitoring for the concurrent use of two antidepressant medications (Wellbutrin SR and Paxil) which were both prescribed for the diagnosis of depression. Although the monitoring forms directed to refer to the social service designee regarding the use of the antidepressant medication, the clinical record lacked evidence of social service designee involvement. Review of the Nurse's Notes for R35 indicated the following: - On 8/3/13, at 6:30 p.m. a note indicated, "Resident refused heel and elbow splints [R35 did not have elbow splints ordered], Resident stated, 'he doesn't need them.' Writer informed resident about the importance of wearing splints, and the positive outcomes. Resident acknowledges info, and still refused." - On 8/4/13 (no time documented), a note indicated, "Res [resident] refused to wear any of his splints stated doesn't need them any more unable to verbally redirect." - On 8/8/13, at 4:00 p.m. a note indicated, "Pt had refused splints..." - On 8/13/13, at 10:50 a.m. a note indicated, "Res also refused splints today would not allow them to be placed on @ all." At 6:00 p.m. a note indicated, "Pt refused splints again today, got up for meals." - On 8/15/13, at 7:00 p.m. a note indicated, "Refuses splints to be on."	F 250		

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F 250	Continued From page 89 Although the Nurse's Notes indicated R35 refused the splints/braces frequently, the clinical record lacked evidence R35 consistently refused the splints/braces or that R35 was reproached to offer the braces after a refusal. The clinical record did not indicate if the splints/braces were offered to R35 on the days he was observed without the braces. Although the Nurse's notes identified refusals of the splint/braces, the clinical record did not identify R35 had refused ROM. On 8/16/13, at 9:30 a.m. when asked about behavior monitoring for mood, reporting of behavior or mood problems and target behavior monitoring the SSD stated, "My involvement has been limited." SSD verified she completed the mood and behavior sections of the care plan and confirmed the care plan did not address R35's refusals of his orthotic devices for his lower extremities. SSD stated it was a team effort to address behaviors, but then stated, "[We] Currently have no behavior program here. It's being implemented. I need help on how to gather the information and then run with it." R8 was involved in altercations primarily related to the television channel, however, the antecedent was not identified and a plan developed to minimize risks to the resident and his peers. In addition, evidence was lacking to show R8 received follow up care by a psychiatrist as recommended by crisis unit staff, or that an alternative to nursing home placement was being sought as recommended by the primary physician R8 requested an interview with the surveyor on 8/12/13, at 1:00 p.m. The resident reported his name was being slandered by a resident who alleged abuse by R8. R8 was observed later that day at 8:00 p.m. in the dining/day room as he and	F 250		

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R85 (the resident who alleged abuse by R8) were yelling. R8 was leaning forward repeatedly in his wheelchair toward R85 and although staff intervened, the resident continued his verbal outburst. The third floor dining room was not visible when staff sat at the nurse's station to intervene for potential resident to resident altercations.

On 8/14/13, at 6:00 p.m. R8 was again observed yelling in the dining room during the dinner meal. Staff present was unable to redirect R8 and the DON intervened to calm R8.

R8's Resident Admission Record from 2008 revealed diagnoses including narcissistic personality disorder with anti-social traits, adjustment disorder with depression, anxiety, and a stroke with partial paralysis.

R8's care plan initiated 9/29/08, revealed the resident was at risk for harm to himself or others related to vulnerable adult status. His displayed inappropriate behavior and an altered mood state, anger with staff, verbally abusive/name calling, refusing cares, disruptive behaviors in common areas, swearing and yelling in dining room, physically arguing with staff and others, and was described as very impulsive and easily angered by other residents. Although the antecedent (preceding cause) in the majority of altercations was related to conflicts over the television channel in common areas, the antecedent was not identified in the resident's care plan with interventions to minimize future altercations. Interventions in the care plan included anti-psychotic, anti-depressant, and anti-anxiety medication as needed. Staff was directed to offer choices, remind him name calling

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F 250	Continued From page 91 was inappropriate, attempt re-direction, re-enforce capabilities and competencies. remove him to his room to calm down as needed, set limits, leave him to cool off when he was verbally aggressive and check back, remind him to speak softer, leave space between tables in common areas, discuss keeping the peace, listen to concerns, express appreciation for efforts to be a gentleman, reinforce positive outcomes, discuss past roles, use kindness, encourage puzzles, psychology appointments as needed, inform family of behaviors, and call 9-1-1 for crisis intervention if R8 displayed "extreme verbal and physical abuse." The significant change MDS dated 6/7/13, revealed a BIMS score of 11/15, or moderate cognitive impairment with evidence of delirium and psychomotor retardation (slowed brain activity). The resident displayed verbal and physical behavior directed toward others one to three days per week. The CAAs triggered behavioral symptoms, but was not addressed in the CAA narrative summary. Incident reports reflected ongoing altercations between R8 and other residents. In several cases, R8 was sent 9-1-1 to crisis, and was returned to the facility. The reports consistently inaccurately noted there were no patterns of previous altercations. Reports were as follows: 1) On 8/27/12, at 7:00 p.m. an altercation over the television (TV) ensued in an argument where R8 struck R78 on the hand leaving a 3.0 by 1.5 centimeter bruise. The RN responded to yelling in the dining room and saw a NA intervening to prevent R8 from charging R78. It was noted the resident saw the in-house psychologist as needed	F 250		

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F 250	Continued From page 92 and a psychiatrist in the community. The SSD also talked to the primary doctor regarding alternative placement in the community that would better suit R8's behaviors. SSD planned to make a referral for relocation services for a more appropriate environment, however, the record lacked documentation showing the referral was made by the SSD. 2) On 9/9/12, R8 asked R599 to move out of his way and when he did not move fast enough, the R8 became angry and elbowed the other resident in the arm and attempted to push him out of the way. It was noted the SSD was in the process of requesting Hennepin County Relocation Services to assess to see if R8 was appropriate for a group home setting and the resident was seen by the in-house psychologist the following day. 3) On 12/3/12, at 4:20 p.m. R8 had an altercation with R54 over the TV channel, and R8 scratched the resident on the left shoulder and threatened to break the resident's laptop. Staff immediately intervened and separated the residents. R54 was sent to his room and R8 was sent out 9-1-1 and admitted to the crisis unit for evaluation and to keep others safe. The resident was evaluated by the psychiatrist, medications were changed, and the resident returned to the facility two days later. The plan was for the psychiatrist to see the resident monthly for the next 3-6 months, but documentation to show follow through on the appointments was not documented in R8's medical record. The SSD would monitor the resident's behavior, and staff was to follow the care plan interventions. 4) On 12/31/12, a report revealed R8 had another altercation over the TV channel, and he verbally	F 250		

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F 250	Continued From page 93 threatened R76. R8 was sent 9-1-1 to a crisis unit for evaluation and to keep the others safe. The follow up investigation on 1/4/13, revealed R8 was escorted to his room, and the SSD was attempting to get records so he could be seen by the in house psychiatrist. The SSD planned to update the psychologist on his next visit on 1/14/13 to request a more specific behavioral plan. According to the nurse practitioner the plan was to have the resident seen by the in house psychiatrist every month for the next 3-6 months. The chart lacked documentation of a psychiatrist visit on 1/14/13, and lacked documentation of a behavioral plan that addressed the antecedents and how to intervene when the resident became aggressive other than to call 9-1-1. On 8/16/13, at 8:43 a.m. the SSD stated she was unaware of the physician's opinion the nursing home may not be an appropriate setting for R8, and stated she had been attempting to get "ammunition" to give the resident a 30-day discharge notice. The SSD had requested a behavioral management plan for R8 and was told by the psychologist that other residents should be removed from the area, but the other residents had refused because they were not doing anything wrong. The SSD explained that R8 was very territorial and refused to watch the TV in his room. SSD was unaware the resident's care plan did not address his physical aggression other than to have the resident removed from the facility. The SSD further stated that when R8 acted out, she had restricted him to his room, but when she came back into the facility she would find him in the dining room because the plan (written in the communication book) had not been followed by staff. The resident was ill in May and June 2013, but as he recovered he began acting	F 250		

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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F 250	Continued From page 94 out again.The SSD said they attempted to find alternate placement for the resident, but he refused to go stating he and his family wanted him to stay at the facility. The SSD asked, "How can he get away with this behavior?" She added that when 9-1-1 was called, "They do not always take him out to HCMC [local hospital]. If he refuses they leave him here." Bruises: R56's MDS dated 4/24/13, indicated moderate cognitive impairment with inattention and disorganized thinking. R56 required extensive assistance of one with bed mobility, transfers, eating, dressing, grooming, personal cares, and toileting. The CAA summary indicated R56 had behavioral symptoms of resistive and combative to cares. R56 was noted to have bruises on his shoulders that appeared to be in the shape of fingerprints on 6/18/13. Six staff members were interviewed and education was provided to three staff on proper repositioning techniques. The injury was determined "most likely from assisting with positioning during cares." The diagram on the incident report indicated bruises on the on the shoulder, above the arm pits bilaterally. The injury was not reported to the SA. On 8/16/13, at 8:43 a.m. the SSD stated staff would report immediately to administrator, the DON, SSD, Hennepin County and the SA. If there was an allegation of abuse, staff were removed until the investigation was completed, and then the results of the investigation were reported to administrator, Hennepin County and SA. When the late reporting was discussed, the SSD did state that she had created and provided	F 250		

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F 250	Continued From page 95	F 250		

education on how to report for the staff, but she continued to work with them on timely reporting since the staff wait for her to report. The SSD further stated that she had been directed by prior administration not to report the above cases to the SA, even though she questioned the situations. The SSD had been working on improvement of the abuse tracking log and the grievance log. The SSD further stated that the DON investigated complaints against the staff and the SSD investigated the others, such as resident to resident altercations. All allegations of sexual abuse, corporal punishment, etc. would be investigated. When asked why the resident to resident altercations and elopement were not in the policy, the SSD stated that's a corporate policy you'll need to speak to the administrator and DON.

8/16/13 at 8:43 a.m. SSD the person identified for abuse concerns stated staff would report immediately to administrator, the DON and SSD, Hennepin County and the SA. If allegation of abuse staff were removed until the investigation was complete, then report to Administrator, Hennepin County and SA the results of the investigation. When the late reporting was discussed, SSD did state that she had created and provided education on how to report for the staff, but she continued to work with them on timely reporting, since they wait for her to report. SSD further stated that she had been directed by prior administration not to report the above cases to the SA, even though she questioned that. SSD had been working on improvement of the abuse tracking log, and the grievance log. SSD further stated that the DON investigated complaints against the staff and SSD investigated the others, such as resident to resident altercations. All

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F 250	Continued From page 96 allegations of sexual abuse, corporal punishment, etc would be investigated. When asked why the resident to resident altercations and elopement were not in the policy, SSD explained that it was a corporate policy, and "You'll need to speak to the administrator and DON."	F 250		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a homelike environment and personalize the space for 1 of 4 residents (R35) reviewed for activities of daily living. Findings include: R35's room was observed on 8/12/13, and the room only contained a bed, bedside dresser, television, and a fan. The walls were void of pictures and behind the television (TV) was dusty picture that was not easily visible. On 8/12/13, 4:57 p.m. R35 stated his belongings were in "storage." R35 verified he had no personal items on the wall, and stated he would not mind having pictures on the wall. The resident indicated "I was not informed I could bring personal items into the facility when I came here."	F 252	**F252** 1. Corrective Action: A) Resident #35 has been provided with items to personalize his room and make it more home-like. 2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by this deficient practice. B) All resident rooms were evaluated for a personal, home-like appearance. 3. Date of Completion: 10/3/2013 4. Reoccurrence will be Prevented by: B) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning.	

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F 252	Continued From page 97 R35 was observed to be lying in bed awake and blinds slightly open. The TV was not on at the time. On 8/13/13, at 1:23 p.m. R35 was randomly observed to be up in his chair, and then was transferred to his bed by two facility staff. Prior to being transferred observed the blinds completely shut, R35 sitting in his room and room lights on. On 8/14/13, during random observations at 7:30 a.m. R35 was observed to be dressed and lying in bed on his back awake with blinds slightly open observed bed was lowered to the floor. R35 stated he was dressed at 6:30 a.m. and left in bed. On 8/14/13, at 9:27 a.m. R35 was transferred from the wheelchair to the bed observed to be laying in his back blinds completely shut and lights were out in room. During all random observations R35 was observed lying in his bed most of the time and only came out of room during meals. At no time during the observations was the tv on for R35 to watch. R35's quarterly Minimum Data Set (MDS) dated 5/14/13, indicated a Brief Interview of Mental Status (BIMS) revealed a score of 13 out of the possible 15 for cognitive patterns indicating mild impairment. On 8/16/13, at 2:38 p.m. both the administrator and the environmental service director (ESD)-C verified R35 had no pictures on the walls and the room was not personalized or homelike. The administrator planned to talk to the social	F 252	5. The Correction will be Monitored by: B) Director of Nursing or designee	

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F 252	Continued From page 98 services designee-A to see what the resident wanted on the walls and would check to see if there was family involved to provide personal items from home.	F 252		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care for the use of an orthotic device for 2 of 3 residents (R45, R35); for 1 of 8 residents (R45) who received a psychotropic medication; for 1 of 6 residents (R45) who had eloped from the facility; for 2 of 3	F 279	**F279** 1. Corrective Action: A) The care plans of resident #45 were reviewed and revised to reflect the elopement risk and the use of the Wander Guard; the use of orthotic devices and performance of ROM and what to do if the resident refuses; Depakote and the target behaviors as well as the indications for the use of the medication and adjustment difficulties related to nursing home placement. B) The care plan of resident #35 was reviewed and revised to reflect the need for an orthotic device and ROM. C) The care plan of #68 was reviewed and revised to reflect the need for behavioral interventions. The recommendations from the psychologist were added to the care plan. D) The care plan of resident #1 was reviewed and revised to address the resident's comfort needs related to pain. The pain care plan addresses both non-pharmacological and pharmacological interventions.	

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F 279	Continued From page 99 residents (R45, R35) who received range of motion (ROM) services; for 1 of 1 resident (R68) who displayed behavioral/emotional status; and for 1 of 1 resident (R1) who had pain. Findings include: R45's care plan was not developed to address elopements from the facility, application of a left splint, left elbow brace, an ankle foot orthotic (AFO) on the left foot and ROM. The facility did not include R45's use of Depakote (a mood stablizing medication) on the care plan. The Resident Admission Record dated 9/19/12, indicated R45 was admitted with diagnoses to include vascular dementia, dysphagia, muscle spasms, persistent mental disorder, pain, depressive disorder, and left hemiplegia. The annual Minimum Data Set (MDS) dated 9/25/12, indicated R45's a Brief Interview of Mental Status (BIMS, a tool used to measure cognition) score could not be completed and identified R45 had short and long-term memory impairments; R45 required limited assistance with walking in and out of his room and transferring; R45 required supervision with locomotion on the unit and required extensive assistance with locomotion off the unit. The MDS indicated a cane and/or a wheelchair were his mobility devices. The Cognitive Loss/Dementia-CAA (Care Area Assessment) dated 9/25/12, identified R45's cognitive losses, R45 was not independent with decision making skills, was inattentive, had disorganized thinking, physical behaviors towards others and rejection of cares. The CAA identified	F 279	2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by the same deficient practices. B) The care plans of all residents receiving orthotic devices and ROM were reviewed and revised as appropriate. C) The care plans of all residents at risk for elopement and in need of Wander Guard devices were reviewed and revised. D) The care plans of all residents on psychotropic medications were reviewed and revised to reflect the target behaviors and the indication for use of the medications. E) The care plans for all residents with in need of behavioral interventions/target behaviors related to adjustment difficulties were reviewed and revised to reflect their current needs. F) The care plans of all residents being seen by the psychologist were reviewed and revised to reflect the suggested interventions. G) The care plans of all residents with pain were	

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F 279	Continued From page 100 R45 had "a difficult time adjusting to the move" and identified specific physical behaviors, suicidal risk and referral to the psychiatrist. The Acitvities of Daily Living (ADLs) Functional Status/Urinary Incontinence/Pressure Ulcers CAA identified R45 was able to ambulate short distances with staff assistance and a quad cane, but the wheelchair was R45's primary source of locomotion. The CAA for Falls/Psychotropic Medication Use dated 10/2/12, indicated R45 had balance problems, was not steady, but was able to stabilize without staff assistance. The CAA indicated R45 "could be impulsive at times." The CAA identified R45 had impaired mobility, spasticity, left Hemiplegia, and contracture of his left hand. The CAA further indicated, "He will occasionally refuse to wear his left hand splint & LLE [lower left extremity] AFO." Although the CAA identified R45 had a contracture and occasionally refused the splint and AFO, the CAA did not identify the left elbow brace and did not identify a ROM plan. The quarterly MDS dated 6/21/13, indicated R45 had a BIMS score of 10 (moderate cognitive impairment); he required extensive assistance with ADLs of transferring, locomotion on and off the unit, dressing and grooming, toilet use; he required limited assistance with walking in and out of the room. Elopement: The Risk of Elopement/Wandering Review indicated R45's potential risk factors for elopement were reviewed. The reviews indicated the following: -On 9/20/12, the review identified R45 "tries to go out stairway exits which have stop signs." The review indicated R45 "has Wanderguard on" and a tabs alarm on at all times. The review indicated	F 279	reviewed and revised to reflect both non-pharmacological and pharmacological interventions. H) Nursing staff members were educated on the need to perform ROM as ordered and to document the procedure, apply orthotic devices as ordered, to monitor residents at risk for elopement according to the care plan interventions including the Wander Guard, monitor behaviors and adjustment difficulties and report accordingly, monitor for pain and try non-pharmacological interventions as well as pharmacological, and to follow the recommendations of the psychologist as noted on the care plans. 2. Date of Completion: 10/3/2013	

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F 279	Continued From page 101 R45 had personal safety devices applied, had "frequent monitoring" but did not identify the frequency of the monitoring and "Wanderguard." -On 12/19/12, and 6/15/13, the reviews identified R45 was not at risk for elopement or wandering. -On 7/2/13, the review indicated, "Leaving into facility parking lot without notifying staff. States, 'I want to exercise.' Cognitive/physical issues unsafe without supervision." The additional comments section of the review indicated, "Wanderguard placed." Although the reviews indicated a Wanderguard was applied to R45 after the 9/20/12 review, the clinical record indicated a Wanderguard was "applied" to R45 again on 1/9/13. A note on 2/16/13, indicated the Wanderguard remained on. The clinical record lacked evidence if and when the Wanderguard was removed. Although a Wanderguard was documented as "applied" on 7/2/13, the clinical record did not identify if a Wanderguard was applied on 7/1/13, or after the 7/2/13, elopements from the facility. The clinical record lacked evidence R45's elopements on 7/29/13 and 7/31/13, were reviewed. A hand written care plan update dated 7/13 indicated, "1 Wanderguard applied [crossed out] initiated - check placement/function per protocol. 2 Post photograph of resident at appropriate place 3 Allow safe mobility in uncluttered environment 4 Encourage movement & exercise in environment 5 Redirect & reorient in gentle manner 6 Offer calm reassurance, 7 Reapproach if resistive 8 Cont [continue] walks outside w/ [with] staff 1-2 x day weather permitting." In addition, the care plan identified R45 could be physically and verbally abusive; he resisted care,	F 279	3. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 4. The Correction will be Monitored by: A) Director of Nursing or Social Service Director or their designee	

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F 279	Continued From page 102 made negative statements, and he had a history of "attempting to choke self with hand." Although the care plan identified R45 had a wanderguard. The care plan did not identify R45's elopement risk, elopements from the facility or attempts to enter unsafe areas of the facility, such as the stairwell. The care plan lacked interventions to address prevention of elopement, such as placement of the wanderguard, R45's history of attempts to remove the wanderguard, reasons for the wanderguard. Although the program identified a "walking program" for R45, the care plan did not identify if R45 was supposed to walk with a cane or to be escorted while R45 used a wheelchair. The Elopement Assessment policy and procedure dated as revised on 5/15/13, identified the facility policy was to assess each resident to identify potential risk factors for elopement. The policy identified, "All residents will be assessed on admission and annually for elopement. Those residents determined to be 'at risk' for elopement will be assessed quarterly." The policy directed the completion of the "Elopement Risk Assessment [Risk of Elopement/Wandering Review]." The policy further directed to apply appropriate interventions from the "list" at the bottom of the form, directed to complete an "elopement prevention/management care plan." Depakote and devices: The Physician's Orders dated 7/31/13, indicated Depakote 125 milligrams (mg) one capsule sprinkles by mouth (PO) were ordered twice daily (BID) were ordered for diagnosis of "anxiety." The Depakote was increased to 250 mg PO BID on 7/30/13. The orders also directed to staff apply/provide the following: "Left Hand Splint on in AM, off at bedtime	F 279		

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F 279	Continued From page 103 Left Elbow Splint on in AM off at bedtime AFO Brace to left ankle/leg on in AM, off at bedtime Wash left hand with soapy water and dry twice daily Range of motion to left upper extremity and left lower extremity twice daily Ace elastic bandage 4" wrap both legs daily PRN [as needed] to protect skin if using AFQ [sic] brace if pt allows." The care plan dated 10/9/12, identified R45 had, "Impaired Communication r/t impaired cognition, dementia - persistent mental d/o [disorder]...ability to make self-understood & understand others is impaired." The care plan for self-care deficit dated 10/9/12, identified R45 had impaired mobility, spasticity, left hemiplegia, contracture of left hand & cognitive impairment. The care plan identified, "*He will occasionally refuse to wear his Left hand splint & LLE AFO." The care plan did not address ROM and did not identify interventions to address R45's refusals. The care plan did not identify use of the left elbow brace. A care plan dated 10/9/12, identified R45 was at risk for side effects from psychotropic drug use and identified R45 received "antidepressant med [medication]." The care plan did not include the use of Depakote. A hand written care plan for Falls dated 10/21/12, identified R45 had potential for fall r/t weakness and left hemiplegia (paralysis on the left side). The care plan dated 7/31/13, indicated, "Resident prefers activities that identify with prior lifestyle i.e. walking program" and identified R45 would "have staff walk him at 10 AM and 2:30 PM. If he is compliant with sticking to these times resdient [sic] will get a treat of his choosing. Resdient [sic] to sign a walking	F 279		

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F 279	Continued From page 104 program contract agreeing to above." The interventions further directed, "OT [occupational therapy] to work with resdient [sic] (modified community integration with behavior mod)." On 8/19/13, at 3:07 p.m. the DON confirmed elopement risk, the use of splint, brace, AFO, and ROM, as well as the use of Depakote should have been care planned. R35's care plan did not address a ROM program or ankle boots. Although the care plan identified R35 wore splints (braces) on both legs and he "threw them [splints] on the floor," the care plan did not identify interventions to address R35's refusals of the ROM or the splints. The care plan for Alteration in mobility dated 3/15/10, indicated R35 had a "hamstring stretch program" daily, directed to set up for the program starting 10/4/10. The care plan did not direct how to complete the stretch, such as for how long or how many repetitions or the type of ROM to apply for the stretch. A hand written update directed, "Bilateral leg splints on 1 hr [hour] after meals when in bed." [undated] An update dated 7/16, "Refusing leg splints throws on floor." A note dated 6/12/13, "Pt [Patient] refuses leg gard" (leg guard on wheelchair (w/c) behind foot pedals added 7/12. The care plan did not address the use of ankle splints. The care plan did not address interventions to address R35's refusals of the splints, leg guard (foot buddy) or ROM. The Diagnoses Report - Clinical dated 3/31/11, indicated R35 had the following diagnosis: diabetes mellitus type II, peripheral neuropathy, gout, obesity, dementia, pre-glaucoma, and	F 279		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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F 279	Continued From page 105 depression with anxiety. The comprehensive MDS dated 2/13/13, indicated R35's BIMS score was 12, identified no changes with ADLs. The MDS identified impairment in both lower extremities. The CAA for ADL's/Urinary Incontinence/Pressure Ulcer dated 2/27/13, indicated R35 was totally dependent on staff for grooming, bathing and dressing. The CAA indicated, "He is assisted with all ADLs & mobility as needed." The quarterly MDS dated 5/14/13, indicated R35 had a BIMS score of 13 (mild impairment). The MDS indicated R35 was non-ambulatory, required total assistance with transfers and toilet use; extensive assistance with bed mobility, locomotion, eating, dressing and personal hygiene. The MDS identified impairment in both lower extremities. The Physician's Orders dated 7/28/13, directed to apply knee splints to both legs. The splints were to be put on for one hour after breakfast and lunch; Ankle Splints both heel/elbow boots were to be applied starting at 2:00 p.m. thru the morning during sleep hours.Range of Motion Program in morning and afternoon during the day and directed to complete the ROM program while in R35 was in bed. On 8/19/13, at 3:07 p.m. the DON verified there was no policy on splint/brace or orthotic device application, assessment, care planning or maintenance. R68 had a physician order for Effexor Extended Release (XR) 75 mg (an antidepressant) at bedtime for depression since 5/17/12. R68's plan of care did not address non-pharmacological	F 279		

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F 279	Continued From page 106 approaches to address depression. The plan of care, initiated on 10/8/12, noted the resident was at risk for side effects from psychotropic drug use and staff was instructed to observe for medication effectiveness and monitor for side effects. The care plan also referenced the use of monthly behavior intervention/flow sheet for additional side effects and refers to facility psychologist or psychiatrist as needed. The care plan also address an alteration in thought process related to the resident's diagnosis of failure to thrive, cardiovascular accident (CVA) and chronic kidney disease. Staff was instructed to allow the resident time when speaking, repeat questions and re-direct as needed. The care plan did not address specific mood/behavioral interventions. A review of the medical record and plan of care lacked evidence that the recommendations made by the psychologist were reviewed by the interdisciplinary team or attempted to implement the recommended interventions into the plan of care. The resident was seen for a psychological assessment on 10/22/12. The diagnostic assessment indicated the resident was being seen to evaluate mood disposition, cognitive status and to assist with treatment plan recommendations. The assessment reported the resident's mood appeared stable and he denied feeling helpless or hopeless. He admitted he had difficulty adjusting to the nursing home facility. The psychologist documented there was no evidence of delusions or hallucinations. It was documented R68 did appear to have cognitive dysfunction and the psychologist did make a diagnostic impression of adjustment disorder with depressed mood features and indicated the	F 279		

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F 279	Continued From page 107	F 279		

severity of the resident psychosocial stressors were severe related to disability issues, cognitive dysfunction and loss of independent living. The psychological assessment noted R68 might benefit from involvement with social and sensory stimulating activity where structure and assistance to include him. The psychologist also recommended the "one-minute program approach" where team members used the strategy of "killing" the person with kindness, soliciting his input and ideas as well as offering suggestions on pleasurable interests that he might pursue. The psychologist noted R68 showed a tendency toward avoidance.

The CAA, completed on 7/12/13, noted the resident declined to participate in the assessment process. She indicated the resident did have disorganized thoughts and was inattentive. The CAA also noted R68's mood was stable and he was seen by the facility psychologist as needed.

A significant change MDS was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. The MDS reported R68 had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares.

An interview was completed with R68 on 8/14/13, at 3:15 p.m. he resident was by himself, sitting on the edge of his bed with the room darkened. The resident denied any depression. He reported he did not understand why he was at the facility and did not want to stay at the facility. He reported he wanted to return to his apartment and live with his

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F 279	Continued From page 108 three sons. He also reported he did not understand why he was going to dialysis and did not feel it was "making him feel any better." An interview with R68 was completed on 8/16/13, at 8:30 a.m. R68 was observed in his room by himself sitting on the edge of his bed. His TV was on but he did not appear to be watching. R68 appeared alert and oriented to person and place. The resident continued to deny any medication refusals or resistiveness to personal cares. An interview with R68 was completed on 8/19/13, at 9:55 a.m. He again was by himself, sitting on the edge of his bed. The television was on but the sound was very low and he did not appear to be watching. His conversation was appropriate and no obvious confusion was noted. The resident continued to deny any medication refusals or resistiveness to personal cares. An interview with social service designee (SSD)-A was completed on 8/19/13, at 12:14 p.m. SSD acknowledged behavioral/mood interventions had not been developed/implemented into the plan of care. She indicated the resident did have episodes of resisting care, refusing medications/treatments and being non-compliant with medical recommendations. An interview with the DON was completed on 8/19/13, at 12:16 p.m. and acknowledged behavioral and non-medication approaches for mood should be part of the care plan process. She reported the MDS coordinator was responsible for the care plan development and implementation of this and it had not been done. An interview with licensed practical nurse	F 279		

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F 279	Continued From page 109 (LPN)-E, who was identified as the MDS coordinator was completed on 8/19/13 at 12:33 p.m. and reported she was not responsible for developing the care plan for mood/behavioral issues. She reported social service was responsible for that. LPN-E reported that mood monitoring is not being done for R68. She also reported that target behaviors for depression were not being done. The facility Care Plan policy, last reviewed on 3/5/97, specified each care plan would be unique and individualized, addressing all services required by the resident to deal with the functional problems identified by each assessment of the entire health care team. The recommendations made by the consulting psychologist were not included in the plan of care or any discussion regarding the rationale for not including the recommendation in the plan of care. R1's Resident Admission Record dated 1/16/13, indicated R1 was admitted with diagnoses to include brain injury, lupus, and osteoarthrosis. A care plan was not developed to include R1's identified pain. A patient evaluation from the neck and back clinic dated 12/5/12, and noted as filed in the chart 6/13/13, indicated R1 had neck and back pain with a treatment plan of spinal adjustments, heat/cold, muscle stimulation and stretch. The admission MDS dated 1/22/13, indicated R1 had occasional, mild pain. The quarterly MDS dated 4/23/13, indicated R1 had almost constant pain which was severe and made it difficult to sleep at night, and limited day-to-day activities because of pain. The quarterly MDS dated 7/23/13, indicated R1 did not receive	F 279		

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F 279	Continued From page 110	F 279		

non-medication interventions for pain, had no pain present, and had a BIMS score of 15 which indicated cognitively intact.

A Physician's note dated 6/5/13, indicated R1 had "chronic and ongoing back pain" and was "working on getting a TENS [transcutaneous electrical nerve stimulation] unit for her back pain."

The Nurse Practitioner Progress note dated 7/19/13, indicated R1 had a wound on the posterior aspect of the second toe which R1 indicted was "tender."

A Comprehensive Pain Data Collection & Assessment dated 7/23/13, indicted R1 had mild pain at the time of the assessment with the worst pain as moderate.

Review of the care plan for R1 received 8/16/13, revealed pain was not identified as a problem, goals for pain were not identified and interventions for pain were not developed.

The June 2013 Medication Administration Record (MAR), revealed R1 received Neurontin three times daily and received Oxycodone 5 mg on 14 occasions. Review of the August 2013 MAR, revealed R1 received Neurontin three times a day for neuropathic pain and seizures, and Oxycodone 5 mg on 8/17/13.

The Resident Centered Pain Care policy dated 12/1/08, directed "Every resident care plan includes pain or the potential for pain. The individual goals for pain management are determined by the resident in collaboration with the interdisciplinary team. Interventions for pain

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F 279	Continued From page 111 are individualized for each resident and include both drug and non-drug approaches."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to update the plan of care for 1 of 1 resident (R49) when R49's right foot ulcer had healed and now was at risk for developing future potential ulcers on the feet due to wearing shoes. Findings include:	F 280	**F 280** 1. Corrective Action: A) The care plan of resident #49 was updated to reflect that the wound has healed and to include measures to prevent recurrence. The care sheet was reviewed and revised to reflect the resident's current needs related to prevention and foot wear. 2. Corrective Action as it applies to Other Residents: A) All residents have the potential to be affected by the same deficient practice. B) The care plans of all residents with current wounds or healed wounds were reviewed and revised to reflect their current needs including measures to prevent worsening or recurrence of wounds. C) Nursing staff was educated to on the need to revise care plans as wounds heal and to add preventative measures to prevent worsening or recurrence of wounds. 3. Date of Completion: 10/3/2013	

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F 280	Continued From page 112 R49's Resident Admission Record dated 6/12/12, noted R49 to have diagnoses of diabetes and peripheral vascular disease. On 8/19/13, at 9:46 a.m. licensed practical nurse (LPN)-D was overheard to tell the nursing assistant (NA)-J that R49 should not have shoes on, because of her pressure ulcer, NA-J then removed the right shoe. On 8/16/13, at 9:56 a.m. R49 was observed in the wheelchair wearing a shoe on the left foot and a sock on her right foot. She has poor circulation markings on her skin on bilateral lower extremities and was carrying a stuffed animal horse. R49 was calling out quietly "Call the police, call the police!" R49's care plan dated 6/25/12, indicated R49 had a lack of comprehension at times. The potential for alteration in skin integrity related to decreased mobility, incontinence and diabetes. The care plan did indicated a pressure reduction mattress was in place, and skin should be observed for signs or symptoms of breakdown. The care plan lacked mention of the development and healing of the right foot ulcer and any interventions to maintain the skin integrity of the healed right foot ulcer. The Treatment Adminsitration Record (TAR) August 2013 stated "Pt should not wear shoes, just socks or slippers due to ulcers." The TAR lacked evidence the nursing staff were documenting the shoes were being left off from 8/1/13 to 8/16/13. On 8/16/13, the TAR noted the nursing order to not wear was discontinued, however, there was no documentation in the R49's medical record to determine why the	F 280	4. Reoccurrence will be Prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. The Correction will be Monitored by: Director of Nursing or designee	

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F 280	Continued From page 113 nursing order had been discontinued. On 8/19/13, at 10:22 a.m. a chart review was conducted. The August 2013 printed Physician Orders stated "Nursing orders: Pt [patient] should not wear shoes but wear socks or slippers (ulcer on feet are caused by shoe irritation)." On 8/16/13, at 10:02 a.m. NA-J stated the care sheet indicated nothing about R49's shoes. NA-J did "get her dressed and put her socks on, but did not put the shoes on her even though R49 cried give me my shoes." NA-J stated "the NA care sheet had the cares listed on the sheet which donning the shoes" and stated R49 foot had looked unchanged that morning. On 8/19/13, at 9:31 a.m. registered nurse (RN)-A stated since "Pt should not wear shoes, just socks or slippers due to ulcers", was a nursing order, it can be discontinued by nursing when it was no longer is needed, and the care plan was updated to discontinue to order. When RN-A paged through the care plan, she stated I thought it was here, let me look, no additional documentation was provided. On 8/19/13, at 10:41 a.m. the consultant director of nursing (O)-D, stated the NA care sheet did not direct the NA's regarding the donning of the shoes and ulcers on R49's foot. On 8/19/13,at 10:44 a.m. LPN-D stated NA have the care plan on their sheets, and that the NA sheets are updated everyday by the nurse manager. LPN-D was unsure when the order to "not where shoes was started, but it had been awhile."	F 280		

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F 280	Continued From page 114 On 8/19/13, at 10:50 a.m. RN-A, stated not wearing shoes had been on the NA sheet and was just removed last Friday, R49 can now wear shoes again. The plan of care was not revised to include interventions on how staff were to provide care to prevent and /or minimize potential skin breakdown of the right foot.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate care and services were provided according to the residents written plan of care for 1 of 4 (R45) who had a Wanderguard (a security device) placed on the wheelchair for security; for 2 of 3 (R35, R17) for needed assistance with grooming; for 1 of 4 residents (R82) who needed assistance with toileting; for 1 of 4 residents (R87) who was identified at being at risk for falls; and for 1 of 3 residents (R42) who needed assistance with assistive devices and repositioning; and for 1 of 4 residents (R23) for range of motion services. Findings include: R45's Wanderguard was not checked for placement and function as directed by the care plan.	F 282		

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F 282	Continued From page 115 R45's care plan dated 7/31/13, had a hand written update dated 7/13, which directed, "Wanderguard initiated - Check placement/function per protocol." On 8/14/13, at 2:45 p.m. the registered nurse (RN)-B verified the Wanderguard should be checked by nursing staff every shift for placement and function. RN-B verified the device (tester) used to check function of the Wanderguard was missing. On 8/16/13, at approximately 8:00 a.m. the administrator confirmed the facility did not have the testers to check if the Wanderguards were functional. The administrator stated the testers were ordered and would be "arriving today." The administrator confirmed the facility's procedure was to have the Wanderguards checked for function every shift. R35 was not provided shaving and nail care grooming assistance as directed by the care plan on 8/12/13, 8/13/13 and on 8/14/13. On 8/12/13, at 4:41 p.m. on 8/13/13, at 1:23 p.m. and during observations on 8/14/13, from 7:30 a.m. to 9:35 a.m. R35 was observed to have many days growth of beard and quarter inch long fingernails with debris under the nails. At not time during the continuous observations on 8/14/13, was grooming assistance provided. At 10:34 a.m. the licensed practical nurse (LPN)-H explained shaving should be completed as needed and on showerday. LPN-H explained nailcares were completed by the nurse on showerday and nursing assistant (NA) staff should report to her if the nails were long, needed trimming or were soiled. LPN-H stated R35's long	F 282	**F282** 1. Corrective Action: A) Resident #45 had his Wander Guard Bracelet replaced and it is now being routinely checked for placement and function. This information is now on the care plan and the TAR. B) The facility has purchased a new Wander Guard testing unit for staff use. C) Resident #35 has been assisted with shaving and his nails have been trimmed. The care plan and care sheets have been reviewed and revised to reflect the need to perform these tasks routinely. D) Resident #82 has been reassessed related to her toileting needs and the care plan and care sheets have been updated. E) Resident #87 was reassessed related to her fall risk and the need for prevention measures and her care plan and care sheets have been updated. F) Resident #42 has been reassessed for repositioning needs, assistive device needs, orthotic device needs and toileting needs. Her nails have been trimmed. Her care plan	

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F 282	Continued From page 116 and soiled nails were not reported to her. LPN-H stated the razor should have been plugged in by the NA staff for a charge, R35 "trys to shave himself," but "misses a lot" and NA staff need to offer to assist and shave patchy areas. At 10:25 a.m. both NA-H and NA-A verified R35 was not offered the opportunity to shave, the long nails were not reported to LPN-H, verified the razor was visible and not charged. R35's care plan dated 3/15/10, identified deficits with shaving, low motivation, and fatigues easily. The care plan directed to provide total assistance and included a hand written note dated 2/12 - "Res. [resident] wants to be shaved." and directed, "Assist of 1 to shave w/[with] Electric razor daily or PRN [as needed]." The care plan further directed, "Nail care & skin check on bath day." On 8/19/13, at approximately 1:30 p.m. the director of nursing (DON) verified R35 should have been offered the opportunity to shave and the need for nail care should have been reported to the LPN for diabetic nail care. The nail care should have been completed on bathday (8/13/13). R82 was not assisted to the toilet for three hours and forty-one minutes. The impaired bowel and bladder function care plan dated 7/11/13, noted R82 was on a toileting program which decreased bowel incontinence. The care plan directed staff to check resident every two hours and provide incontinence cares/pad changes as needed. The care plan directed staff to assist of one with toileting as needed and if resistive to cares, re-approach with	F 282	and care sheets have been updated to reflect her current needs. G) Resident #17 has been shaven. H) Resident #23 was reassessed for his restorative PROM and ambulation program needs. The care plan and care sheets reflect the current needs and the staff members are documenting about the programs routinely. 2. Corrective Action as it applies to other Residents: A) All residents have the potential to be affected by the same deficient practice. B) The care plans and care sheets of all residents receiving restorative PROM and ambulation programs were reviewed and revised as appropriate. C) The Restorative Nursing Program Policy was reviewed and revised. D) The care plans and assessments of all residents who require toileting assist were reviewed and revised to reflect their current needs. E) The care plans and assessments of all residents requiring assist with	

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F 282	Continued From page 117 another staff person/assist of two as needed. A Goal Analysis Noted dated 7/11/13, indicated R82 "is now toileted & not prompted, toileting program has changed." During continuous observations on 8/16/13, from 7:40 a.m. until 11:21 a.m. R82 was observed sitting in a chair in the dining room on second floor without being assisted to the toilet. At 11:21 a.m. NA-L was asked to assist R82 to the toilet. NA-L stated she had asked R82 if she wanted to use the toilet earlier and R82 had refused; however, this was not observed by the surveyor during continuous observations. NA-L approached R82 and asked her if she needed to go to the bathroom. R82 did not respond to NA-L's question. When NA-L was asked what she does if R82 does not respond to her toileting prompt, NA-L stated she would tell the nurse. At 11:35 a.m. NA-L reported to LPN-D she was unable to assist R82 to the toilet. LPN-D did not respond to NA-L or assist R82 with her toileting needs. NA-L did not re-approach R82. Upon interview on 8/16/13, at 1:03 p.m. the DON stated she expected residents to be toileted according to the plan of care. R87 did not have fall interventions in place as directed by the plan of care. R87's Patient Medical Care Plan for August 2013, included orders for hip protectors on at all times and elbow pads worn at all times. The Nursing Assistant Assignment Sheet	F 282	repositioning were reviewed and revised to reflect their current needs. F) The care plans and assessments of all residents at risk for falls were reviewed and revised to reflect their current needs. G) All residents were checked for facial hair and shaven as necessary. H) The nails of all residents were checked and trimmed as necessary. I) All residents at risk for elopement have been reassessed and Wander Guard devices are in use. The care plans and TAR of these residents reflect the need to check for placement and function. J) The facility has purchased a new tester for the Wander Guard system. K) The policy on Documentation and Nursing Care Standards was reviewed and revised. K) Nursing Staff members were educated on the need to read and follow care plans and group sheets. They were also educated on the Documentation and Nursing Care Standards Policy.	

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

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 282	Continued From page 118 received 8/15/13, directed elbow and hip protectors. R87 was observed on 8/12/13, at 5:45 p.m., 8/13/13, at 1:54 p.m., 8/15/13, at 8:29 a.m., 8/16/13, at 8:12 a.m. without elbow protectors on. RN-A was observed assisting R87 with toileting on 8/15/13, at 9:10 a.m. and verified R87 did not have hip or elbow protectors on. The May, June, July and August 2013, Medication Administration Records were reviewed and the hip and elbow protectors were circled as not being applied with the reason given as "don't see in room." A Physician's Telephone Orders dated 8/14/13, indicated "Ok to d/c [discontinue] hip protectors, elbow protectors and TED hose [anti-embolism stockings] d/t [due to] non coverage." However, this order was not present in the medical record when the record was reviewed on 8/16/13. There was no indication of any alternate fall interventions put in place. When interviewed on 8/16/13, at 11:11 a.m. the nurse consultant stated the facility provides elbow protectors and hip protectors are available from the pharmacy or ones available in the facility. The nurse consultant verified the elbow and hip protectors were put into place as fall interventions. R42 was not positioned and did not have assistive devices applied as directed by the plan of care. A skin integrity care plan dated 7/29/13, directed	F 282	3. Date of Completion: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning 5) The Correction will be monitored by: A) The Director of Nursing or Designee.	

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F 282	Continued From page 119 reposition side to side with no back lying. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of motion and maintain skin integrity. The impaired bowel and bladder function care plan dated 4/6/09, directed staff to check resident every two hours and as needed for incontinence. The potential for abrasion due to scratching self-care plan dated 5/13/10; directed nails will be trimmed every week. The self-care deficit in bathing care plan dated 4/6/09, directed nail care to be done on bath days. The Patient Medical Care Plan dated 7/29/13, included a physician's order for palm protectors on at all times-may remove for cares and bathing. The Nursing Assistant Assignment Sheet received on 8/15/13, directed bilateral palm protectors, toileting assist of one every two to three hours check and reposition, up for two hours AM/PM and position side to side every two hours, remain off back when in bed. During continuous observations on 8/15/13, from 8:11 a.m. until 10:33 a.m. R42 was observed sitting in a wheel chair in her room without palm protectors on. At 10:33 a.m. NA-I and trained medication aide (TMA)-B entered R42's room and assisted her into bed. When asked, NA-I stated she had gotten R42 up in the wheel chair at 7:00 a.m. (a total of three hours and thirty-three minutes) and she repositioned R42 every two hours in the wheel chair. NA-I verified R42 did not have palm protectors on and stated R42 did not have any splints for her legs.	F 282		

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F 282	Continued From page 120 R42 was observed in bed on 8/15/13, at 1:49 p.m. and did not have palm protectors or knee splints on. When interviewed on 8/15/13, at 2:13 p.m. LPN-D verified R42 did not have palm protectors or knee splints on. LPN-D located the knee splints in the closet and stated the NAs should be putting the splints on. LPN-D stated she thought the palm protectors were taken away and R42 was to have wash clothes in her hands. R42's nails were noted to be ¼ inch long, LPN-D stated she usually cut R42's nails on bath day or when she notices they are long. The bath log was reviewed and indicated R42 received baths on Wednesday evenings. When interviewed on 8/15/13, at 2:31 p.m. NA-M verified R42 received a bath on 8/14/13. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed with nothing in her hands. At 9:24 a.m. NA-I verified R42 was lying on her back in bed. R42's toenails were noted to be ½ inch long. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed with nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. LPN-H was approached by the surveyor on 8/19/13; at 11:14 a.m. LPN-H stated R42 was supposed to have palm protectors in her hands or washcloths. LPN-H located one palm protector in the room which she applied to R42's right hand. LPN-H was unable to locate a palm protector for the left hand and stated she would have to call therapy for a new one. LPN-H stated the NAs were to apply the palm protectors after cares and the nurse cut R42's nails with baths.	F 282		

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F 282	Continued From page 121 R17 was observed to have facial hair on her lower chin on 8/12/13, 8/13/13, 8/14/13 and 8/15/13, was not provided assistance to remove the facial hairs. The care plan dated 7/8/13, identified R17 had "self-care deficits related to impaired mobility, weakness and cognitive impairment-left sided hemiplegia. Care plan further indicated R17 received assistance with dressing, grooming and bathing. R17 care plan focus goal directed "will be neat, clean & odor free." On 8/12/13, at 5:39 p.m. observed R17 lying in her bed on her back with numerous facial hairs to the lower chin (approximately a half (1/2) inch in length) down her front neck area. On 8/13/13, at 10:00 a.m. observed facial hairs still not removed. On 8/14/13, at 8:09 to 9:31 a.m. during continuous observations: -At 8:09 to 8:14 a.m. observed R17 up in her wheelchair in her room dressed in a yellowish-green and red print dress. The facial was still present. -At 8:15 a.m. NA-G observed entering R17's room and brought resident to dining room. R17 still observed to have several facial hairs to lower chin and down the neck area. -At 8:24 a.m. observed NA-G offered R17 clothing protector and applied it facing R17 from the front. -At 8:25 to 9:30 a.m. R17 observed in the dining room eating her breakfast, observed several staff came up to resident including NA-F & NA-H and no staff offered to remove facial hair.	F 282		

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F 282	Continued From page 122 -At 9:31 a.m. NA-F came and retrieved the resident from the breakfast meal and took R17 to her room, shut the door and then came out observed to be carrying a plastic bag on her and went to the soiled utility room. - At 9:42 a.m. observed R17 lying in her bed with facial hairs still there and visible. - At 12:15 p.m. observed R17 sitting in the dining room table waiting for lunch observed to still have facial hairs. Again several staff in the dining room area no one offered to remove the hairs for resident. On 8/15/13, at 8:30 a.m. observed R17 in the dining room table eating breakfast still had the facial hairs. On 8/16/13, at 9:21 a.m. interviewed RN-A and LPN-A regarding the facial hair, RN-A stated "facility does not have a facial hair removal policy but once a week staff go around and ask to remove resident's facial hair. Staff was to follow up and re-approach resident if resident refused, it's their right to do so then nursing assistants have to report to the nurse to document the refusal." On 8/16/13, at 1:03 p.m. interviewed the consultant director of nursing (O)-D stated her expectation was staff to remove the facial hair for the resident's daily and as needed as that was a dignity issue especially for female residents. All staff were supposed to continue to re-approach if a resident refused and report to nurse if not able to assist the resident with cares. Above all staff had to follow each resident's plan of care directed by the care plan.	F 282		

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F 282	Continued From page 123 R23 was not provided upper and lower extremity range of motion services as ordered by her physician and as indicated in her written plan of care. The undated Nursing Assistant Assignment Sheet AM/PM directed "PROM [passive range of motion]-slow stretch and Ambulation per PT [physical therapy] recommendations-PM shift." Review of R23's care plan for physical therapy maintenance program dated 1/13, directed resident to ambulate 20 to 50 feet with walker, stretching and PROM program every day. Goal "will complete program qd [everyday]." Current physician orders dated 8/5/13, directed: Ambulation 20 to 50 feet with walker daily hold OT/PT [occupational therapy] to assess and Stretching & PROM daily - see program On 8/12/13, at 4:40 p.m. R23 stated he would like to walk more sometimes as the therapist and the doctor had ordered him to walk at least twice daily but sometimes he never walks. He further stated that he would like to be able to walk more so that he can go with family and outings like other residents in the facility. On 8/14/13, at 1:48 p.m. interviewed NA-G stated she had assisted R23 with PROM but did not know where and who was responsible to complete documentation. In regards to ambulation, NA-G stated the evening shift was to complete the program. On 8/14/13, at 2:12 p.m. LPN-B was interviewed and stated NAs were responsible to complete the PROM then report to the nurse to sign off the	F 282		

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F 282	Continued From page 124 treatment administration record at the end of the shift. LPN-B further stated the ambulation program was on hold as physical therapy was currently working with R23 despite physician order dated 7/10/13, that he had been discharged from therapy secondary to goals have been met. On 8/16/13, at 10:14 a.m. certified occupational therapist assistant (O)-H stated R23 had been picked up 5/14/13, following a physician order after resident had expressed desire to ambulate although original order was for a restorative program. O-H stated original evaluation was completed 10/28/12, for ambulation, standing, transferring and decreased functional mobility which R23 completed and was discharged 12/7/12, from therapy but later found out that R23 was not being ambulated. On 5/13/13, O-H requested an order for ambulation and safety with transfers and R23 started being seen 5/14/13, five times weekly until 7/10/13. During the session, R23 had complained of left ankle pain after two therapists had assisted him to the floor mat in quad position for exercise on 6/4/13, an x-ray was completed no fractures and issue had resolved. O-H further added that staff was educated on resident ambulation program 7/8/13 through 7/31/13, by PT staff including the physical therapist as indicated by documentation and sign-out sheet. On 8/16/13, at 9:27 a.m. interviewed the RN-A stated her expectation is to find a place to keep restorative sheets to ensure staff was documenting the PROM and ambulation after it was completed. RN-A stated also the Policy was currently being reviewed and documentation will be addressed. RN-A further stated that the nurses are expected to make sure all	F 282		

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F 282	Continued From page 125 documentation was completed by the end of their shift daily after they made sure the nursing assistants had completed the task. Later at 11:32 a.m. O-D concurred with RN-A's statement. On 8/16/13, at 4:06 p.m. interviewed O-D, RN-A and O-H stated there was a misunderstanding between the therapy and nursing departments about R23's ambulation program and when it had been restarted again which explained the reason why it was not being completed. The Range Motion (ROM) active and passive policy and procedure revised 8/13/13, directed " Assist the resident as necessary and assess the resident's ability to perform active range of motion. ..... . " The policy lacked a systematic procedure to ensure staff was aware who was responsible to ensure all documentation was completed and where documentation was to be completed according to the frequency ordered. Additionally the policy lacked an on-going systematic communication channel between the therapy and nursing departments in regards to when a resident had been discharged from therapy and appropriate programs to be continued as restorative by nursing.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		

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F 309	Continued From page 126 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify dialysis services that were being provided for 1 of 1 resident (R68) who was received dialysis services; the facility failed to provide services for 1 of 1 resident (R1) who was identified as having pain; and the facility failed to assess, monitor and implement interventions for 1 of 2 residents (R87) reviewed who had bruises of unknown origin; the facility failed to follow physician's order and administer an antibiotic prior to dental appointment for 1 of 1 resident (R68) who had a history of cardiac problems. Findings include: Dialysis: R68's Resident Admission Record dated 9/8/12, noted R68 had diagnosis which included chronic kidney disease (Stage IV) and diabetes mellitus Type II. He attended dialysis three times weekly. R68's care plan was not comprehensively developed related to dialysis; the facility had not followed specific physician orders regarding dialysis and lacked interventions to address emergency services related to dialysis care for R68. On 8/16/13, at 8:45 a.m., a moderate amount of bright red blood was observed on R86's left shirt sleeve. R86 reported his dialysis shunt was bleeding and the nurse changed the dressing. An interview with licensed practical nurse (LPN)-D was done on 8/16/13, at 8:53 a.m. and verified the resident's shunt had been bleeding "a small amount" and she had "reinforced" the area with a	F 309	**F 309** 1. Corrective Action: A)The Dialysis care plan of resident #68 was reviewed and updated to reflect emergency procedures related to the shunt bleeding and what to do if he exhibited signs of infection; and what to do if the resident could not be transported to dialysis due to bad weather or other disasters. His Dialysis diet including foods to avoid and his fluid restriction and the need to monitor his fluid intake at meal times and throughout the rest of the day were reviewed and his care plan was revised. His weights are being checked before and after dialysis as per orders. His blood pressure is being checked before and after dialysis. The physician has been informed that the resident frequently refuses his Kionex. B) Resident #1 pain has been assessed and being re-assessed on regular basis. The pharmacy has been contacted and a plan is in place to assure that the resident receives her medications as ordered. C) A reporting system is in place for bruises of unknown	

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F 309	Continued From page 127 new dressing. She reported that occasionally happened to the resident's shunt and she would inform the physician about the incident. She also reported that she did not know how the dialysis program wanted her to treat the bleeding or if they wanted to be notified of a small amount of bleeding. She verified there was no plan for emergency services for the resident and his dialysis needs. She indicated that in an emergency, she would call his physician and get directions from him. She indicated that if there was bad weather and the transport company could not transport the resident to dialysis, she would call an ambulance to transport him. She reported she was unaware of any other options. The plan of care, dated 10/8/12, noted the resident had dialysis three times per week, was on a therapeutic diet as result of this, received a diuretic medication, was a 2000 cubic centimeters (cc) fluid restriction, and staff were to follow the physician orders for medications, nutritional supplements, obtain vital signs and weights per physician order. There was no identification of any established goals set or approaches/interventions for dialysis services, no plan was implement for monitoring fluid intake, both at meals and on the residential unit. There were no plans in the care plan for emergency procedures or signs/ symptoms the resident may exhibit which require medical consultation/interventions such as infection, bacterium, and septic shock. The Care Area Assessments (CAAs), completed on 7/12/13, noted that the resident had been hospitalized from 6/11/13 to 6/14/13. A significant change Minimum Data Set (MDS)	F 309	origin and resident #87 has been assessed for further bruising. The skin care plan of resident #87 was reviewed and revised to reflect her current needs. D) The MAR and care plan of resident #68 was reviewed and revised to specify the need for Antibiotic Therapy and what type/dose to administer prior to dental appointments. 2. Corrective Action as it applies to other residents: A) All residents have the potential to be affected by these deficient practices. B) The Abuse Prevention Plan and Incident Reporting Policy was reviewed and revised. C) All staff members were educated on the Abuse Prevention Plan and the Incident Reporting Policy. D) Nursing staff members were educated on the needs of patients with dialysis. E) The care plans of all residents receiving dialysis have been reviewed and revised to reflect emergency procedures including what to do in the case of uncontrolled shunt bleeding, signs of infection at the shunt site and what to do in case of	

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F 309	Continued From page 128 was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. He needed extensive assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene. He received dialysis and received a therapeutic diet as result of that. Although, there were some areas of improvement noted on the significant change MDS, it was determined he had declined overall and due to his potential for skin breakdown, the continued need for assistance with transfers and the potential/expectation he would continue to have variations in mobility. It was also documented his status was variable related to his medical condition, dialysis, fragile status and periods of increased weakness. R68's Physician Orders, last signed on 8/1/13, directed staff to weigh R68 before and after dialysis. A review of the medical record revealed in the month of June, 2013-no weights were done before or after dialysis and the only recorded weight for the month was done 6/14/13, which was not a day the resident had dialysis. In July, 2013, the records indicated R68 was weighed before and after dialysis only on 7/16/13 and 7/26/13, and no weights were recorded for 42% of the opportunities. From August 1 to August 13, 2013, the weights were correctly done on two days, August 3 and August 8, 2013, and no weights were done for 58% of the opportunities. An interview was completed with LPN-D on 8/14/13, at 2:25 p.m. She reported that was not	F 309	the inability to transport the resident to dialysis if there is bad weather or any other disaster; fluid and dietary restrictions, fluid intake monitoring, weight monitoring and blood pressure monitoring per physician orders. E) The Pain Management Policy was reviewed and revised and nursing staff members were educated on the need to provide both non-pharmacological and pharmacological interventions as ordered. F) Nursing staff has been educated on the need to contact the pharmacy immediately if there is a medication ordered but not available to administer and that they must contact the physician if the pharmacy is not able to provide a prescribed medication. G) Nursing staff has been educated on the need to contact the physician if the resident is refusing medications. H) Nursing staff has been educated on the need to check the MAR and care plan for Antibiotic orders when a resident is to receive dental services.	

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F 309	Continued From page 129 aware of the resident not being weighed before and after dialysis. She also reported all weight obtained would be documented in the medical record. The Physician Orders, signed on 8/1/13, directed staff to measure R68's blood pressure before and after dialysis. A review of the medical record revealed in June, 2013-blood pressure was taken as ordered on two days (6/1/13 and 6/6/13) and not taken as ordered 53% of the time. During July, 2013-the resident's blood pressure was taken as ordered on four days (7/6/13, 7/16/13, 7/20/13 & 7/30/13) but not taken as ordered 50% of the time. During August 1-13, 2013- the resident's blood pressure was taken as ordered four times (8/3/13, 8/8/13, 8/10/13 & 8/13/13) and no taken as ordered 25% of the time. An interview was completed with LPN-D on 8/14/13, at 2:25 p.m. She reported she was not aware that the resident's blood pressure was not being taken before and after dialysis as ordered by the physician. She reported all blood pressures taken would be charted in the medical record. An interview on 8/14/13, at 1:20 p.m. with the dialysis program registered nurse (DPRN). He reported the staff at the dialysis program contacted the facility and informed them on 6/22/13, the resident's potassium level was critically high and as result, he was seen at a local emergency room for evaluation. A review of the medical record noted on 6/27/13, the facility physician ordered staff to administer Kionex suspension (a medication used to treat elevated potassium levels) 15 grams by mouth every day. Since that order was written, the resident had	F 309	See Health Addendum completion date 10/3/13 Attached	

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F 309	Continued From page 130 taken it twice (7/10/13 and 7/11/13). A review of the medical record lacked any evidence of the physician being notified of the resident's refusal to take the medication. An interview was completed with LPN-D on 8/14/13, at 2:25 p.m. who reported R68 consistently refused the Kionex and she were told just to document that on the Medication Administration Record (MAR). She reported she did not know if the physician had been informed of the resident's refusal to take the medication. An interview with the director of nursing (DON) was completed on 8/16/13, at 3:30 p.m. who verified the findings. The facility policy Dialysis, reviewed 8/13/13, directed staff to develop a comprehensive care plan for residents and should include potential risks and complications, measurable goals for risks/complications and monitoring plan for potential complications. In addition, the care plan should address frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure activity. It should address monitoring of the shunt or access site for signs of infection, alteration of fluid volume, potential for bleeding and care of the access site. The care plan should also address alteration in nutrition and skin integrity and medication with appropriate scheduling as they relate to dialysis schedule. A goal was to be established ensuring that goals and interventions between the facility and dialysis provider were compatible. Pain: R1's Resident Admission Record dated 1/16/13, noted R1 to have diagnoses to include brain injury, lupus, osteoarthrosis, and lumbago. The	F 309		

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F 309	Continued From page 131 facility failed to ensure a pain management program was provided for R1 who had chronic pain. The admission MDS dated 1/22/13, indicated R1 had occasional, mild pain. The quarterly MDS dated 4/23/13, indicated R1 had almost constant pain which was severe and made it difficult to sleep at night, and limited day-to-day activities because of pain. The quarterly MDS dated 7/23/13, indicated R1 did not receive non-medication interventions for pain, had no pain present, and had a Brief Interview of Cognitive Status (BIMS) score of 15 which indicated cognitively intact. An undated letter signed by the certified occupational therapy assistant (COTA) indicated R1 "could benefit from a personal owned TENS unit (transcutaneous electrical nerve stimulation) to help alleviate constant back pain" and "At this time conventional physical therapy has not been successful in alleviating the back pain and that is why it is imperative that [R1] receive a personal TENS unit for her back pain." A nurse practitioner notes were reviewed from 3/13, forward and the following was noted: - On 3/26/13, indicated R1's bedtime dosing of gabapentin (used to treat neuropathic pain) was increased to 600 mg (milligrams) and the 8:00 a.m. and 2:00 p.m. dosing would remain at 300 mg. The nurse practitioner (NP) also ordered warm packs to the back of her neck twice a shift while awake. - A NP Progress note dated 4/17/13, noted R1 had not received gabapentin at 8:00 a.m. and 2:00 p.m. and was complaining of increased pain and had not received the bedtime dosing of	F 309		

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F 309	Continued From page 132 gabapentin for the last two nights related to pharmacy delivery. - On 4/26/13, indicated R1 was encouraged to inform staff when she was having pain and needed pain relief. - On 5/28/13, indicated physical therapy (PT) had been trialing the use of a TENS unit for chronic pain and R1 reported the TENS unit was helping alleviate pain issues. - On 7/19/13, indicated R1 had a wound on the posterior aspect of the second toe which R1 indicted was "tender." - On 8/14/13, indicated R1 reported she had not been using the TENS unit because staff were not helping her as directed by the PT department. The note indicated R1 was to have the TENS unit placed one to two times per day for 30 minutes, once in the morning and once in the evening. The note further indicated R1 reported the current Tylenol (a mild analgesic)she had been trying had not been helpful. A physician's note dated 6/5/13, indicated R1 had "chronic and ongoing back pain" and was "working on getting a TENS unit for her back pain." A PT Daily Treatment Note dated 6/13/13, noted R1 continued to have decreased pain following TENS. A PT/OT/speech therapy (ST) Recommendations to Caregivers dated 6/13/13, instructed "if issues or pt [patient] is not tolerating TENS, please contact therapy department." A Referral Form dated 6/13/13, from the psychiatrist indicated R1 was alert and oriented in three spheres and had no signs of psychosis. A patient evaluation from the neck and back clinic dated 12/5/12, and noted as filed in the chart	F 309		

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F 309	Continued From page 133 6/13/13, indicated R1 had neck and back pain with a treatment plan of spinal adjustments, heat/cold, muscle stimulation and stretch. A Physical Therapy Discharge Summary dated 6/14/13, indicated nursing staff had been trained to apply TENS unit for resident and will continue up to two times per day as she requests. A Physician's Order dated 6/14/13, directed to place electrodes from TENS unit on R1 one to two times per day for 30 minutes, one time in the a.m. and one time in the p.m. A Comprehensive Pain Data Collection & Assessment dated 7/23/13, indicated R1 had mild pain at the time of the assessment with the worst pain as moderate. Current interventions were noted as PRN Tylenol (a mild analgesic) and TENS unit. A Nurse's Notes dated 8/15/13, indicated "offered resident her TENS and she said okay but when nurse went to apply it she [R1] said no." Review of the care plan for R1 received 8/16/13, revealed pain was not identified as a problem, goals for pain were not identified and interventions for pain were not developed. Review of the MARs from April forward noted the following: - April 2013 revealed the bedtime dose of gabapentin was given all days of the month however; the 8:00 a.m. and 2:00 p.m. doses of gabapentin were not administered from 4/1 to 4/17/13. The April 2013 MAR also revealed an order for "apply warm pack to the back of the neck for 20 minutes as tolerated Bid [twice a day] q [every] shift" and was scheduled for once on	F 309		

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F 309	Continued From page 134 nights, once in the a.m. and once in the p.m. - May 2013 MAR revealed an order for ice pack apply to back of the neck for 20 minutes or as tolerated twice per shift and was only scheduled once for the a.m. and p.m. There was no evidence the Physician's Order had changed from warm packs to ice packs. - June 2013 MAR revealed the order for an ice pack to the back of the neck did not have a time scheduled and was not signed as completed for the month of June. The June 2013 MARs revealed R1 received Neurontin three times daily and received Oxycodone 5 mg on 14 occasions. - August 2013 revealed R1 received Neurontin three times a day for neuropathic pain and seizures, and Oxycodone (a narcotic) 5 mg on 8/17/13. Review of the June 2013 MAR revealed the order written as needed (PRN) and was not signed as used for the month of June. Review of the July and August 2013 MARs also revealed the TENS unit was not used. When interviewed on 8/16/13, at 10:00 a.m. R1 stated she had pain in her back, neck, leg and hands. R1 stated the nurses "don't seem to care about the pain" and she tells the nurses all the time about the pain and the "TENS unit went down the drain."R1 stated she had asked to use the TENS unit and the nurse expected me to put it on myself, "she wouldn't." R1 stated she had not asked and the nurse's have not offered the TENS unit since then. When interviewed on 8/13/13, at 1:10p.m. R1 stated she had pain in her back, neck, and legs that doesn't go away and "they only give me Tylenol and it doesn't help." The NP was interviewed on 8/14/13, at 1:59 p.m.	F 309		

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F 309	Continued From page 135	F 309		

and stated she had ordered a TENS unit back in June 2013 for R1's pain. The NP stated she had to keep R1 on narcotic pain medication because the TENS unit had not been used and R1 still had unresolved pain.
Upon interview on 8/19/13, at 9:47 a.m. the COTA stated R1 could not put on the TENS unit herself and the nurses were trained on how to use it. The COTA stated R1 "loved it [the TENS unit] and would be waiting at therapy for treatment." The COTA stated ice was tried for R1's pain and was not as effective. The COTA indicated she was not aware R1 was not using the TENS unit.
Licensed practical nurse (LPN)-H was interviewed on 8/19/13, at 11:32 a.m. and stated R1 had not requested the TENS unit when she was working and she had not offered it to R1.
The Resident Centered Pain Care policy dated 12/1/08, directed "Every resident care plan includes pain or the potential for pain. The individual goals for pain management are determined by the resident in collaboration with the interdisciplinary team. Interventions for

Bruises of unknown origin:
R87 was observed on all days of the survey to be sitting and walking with R82. The facility failed to assess, monitor and implement interventions for R87 who had bruises of unknown origin.

During observation on 8/12/13, at 5:42 p.m. R87 was noted to have dark purple bruising on the knuckles of the left hand and dark purple bruising to the right wrist area. When asked, R87 reported she fell down the stairs.

During observation on 8/15/13, at 9:16 a.m. R87 continued to have the bruising to the left knuckles and the right wrist and another 7 centimeter (cm)

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F 309	Continued From page 136 x 4 cm dark purple was noted to R87's left forearm. On 8/19/13, at 10:06 a.m. R87 was observed to have a dark purple, thumb sized bruise on her left inner forearm. R87's care plan dated 12/13/12, identified her as being at risk for harm from self or others related to a diagnosis of dementia. The care plan does not identify risk for bruising or bleeding. In addition R87's care plan indicated she was resistive to cares with an approach to include "When resident begins to resist care, STOP and try task later. Do not force to do task." The admission MDS dated 12/18/12, indicated R87 had both short and long term memory problems and moderately impaired cognitive skills for daily decision making. A Resident Incident Report dated 3/27/13, noted a 4 cm x 5 cm bruise to R87's outer left hand. The immediate interventions were noted as monitor and redirect and requested Geri-sleeves from the nurse practitioner. RN assessment indicated trial of Geri-sleeves was unsuccessful and to monitor areas and encourage resident not to grab hands, just hold hands. A Resident Incident Report dated 6/14/13, 7:00 a.m. indicated R87 was noted to have a 1.5 cm x 2.5 cm bruise on the left wrist. Interventions noted to monitor skin daily and monitor for and redirect when residents holding arms/wrists to hold hands. Nurse's Notes were reviewed from 4/13 forward and the following was noted: - On 4/29/13, indicated more bruises noted to	F 309		

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F 309	Continued From page 137 body, blue and yellow in color. The last Resident Incident Report was dated 3/27/13. - On 7/6/13, noted multiple bruises on both (unidentified area) remained. - On 7/20/13, indicated R87 had old bruises on both lower arms. Review of the Resident Incident Reports and the Nurse's Progress notes revealed no documentation regarding these bruises. A Physician's Order dated 7/29/13, directed to monitor skin every shift and document new areas in the nurses notes. R82's Behavior/Intervention Monthly Flow Record for August 2013, noted R82 was monitored for "abusive to others" which was noted as occurring two to three days on day shift from 8/7 to 8/12/13. When interviewed on 8/14/13, at 9:19 a.m. licensed practical nurse (LPN)-D stated bruises were monitored in the Nurse's Notes. During an interview on 8/16/13, at 11:11 a.m. the nurse consultant (O)-D stated bruises are tracked on incident reports. On 8/19/13, at 2:09 p.m. the director of nursing was again asked for documentation regarding assessment and intervention for R87's bruises noted throughout the survey. A policy regarding ongoing monitoring of resident's skin condition was requested but no policy was provided. Dental: R68 was to receive an antibiotic prior to dental	F 309		

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F 309	Continued From page 138 appointments/ procedures. R68 had a dental appointment on 8/16/13, and no antibiotic was given. A significant change MDS was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. A Dental CAA was completed on 7/12/13, and indicated R68 was missing some upper and lower teeth. The CAA also noted R68 had poor dentition and did not wear dental partials or dentures. The CAA recommended the staff assist the resident with oral cares as needed. Resident was seen by a dentist on 8/5/13, and the plan was to transition the resident to complete dentures. The dentist recommended R68 have antibiotic prophylactically before the next appointment and all appointments in oral surgery. The resident's physician reviewed the recommendation on 8/9/13. He noted the resident was on renal dialysis with a renal dialysis shunt and known underlying patent foramen ovule (hole in his heart) on a previous echocardiogram. He also noted R68 had an underlying atrial flutter, which was complicating dialysis runs and putting the resident at risk for tachyarrhythmia and after his dental issues are resolved he could have an ablation which might improve his heart condition for atrial flutter. The physician wrote an order on 8/9/13, for	F 309		

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F 309	Continued From page 139 Amoxicillin (an antibiotic) 2 grams orally two hours prior to dental procedures. The order was transcribed and placed on the MAR. The order was transcribed and noted by two facility LPNs. The MAR was reviewed and appeared on the MAR as "Antibiotic before dental appointment" and the date of 8/16/13, was boxed to indicate the date the medication was to be given. The transcribed order did not specify which antibiotic was prescribed, what dose, what route or when it was to be given. On 8/16/13, at 8:55 a.m. a transport driver appeared on the nursing station and announced he was to take the resident to a dental appointment. LPN-D was at the nurses' station at the time and the resident was summoned. LPN-D was questioned regarding the need for the antibiotic prior to the appointment and the resident leaving the facility. She stated R68 had no antibiotic ordered for the appointment. The specific notation on the MAR was pointed out to the LPN-D but stated the order was for a procedure that was cancelled on 8/13/13, but was unsure of what procedure and where. LPN-D indicated she did not know exactly what was going to be done on that date at the dental clinic. The resident left the facility with the driver. The dental consult report was reviewed with LPN-D. The dental consult report dated 8/5/13, specified the need for prophylactic antibiotic use prior to dental appointment. Also reviewed with LPN-D was the written physician order dated 8/9/13. She had verified regarding the need for the antibiotic. The consultant registered nurse (O-D) was contacted and she instructed LPN-D to contact the dental clinic and notify them the resident had not gotten the antibiotic.	F 309		

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure that 1 of 1 resident (R68) was encouraged to assist with activities of daily living (ADLs) to minimize the risk of decline in ability and to provide appropriate care. Findings include: R68 was not encouraged to actively participate in personal cares and appropriate nail care was not provided. During the observation of R68's personal cares on 8/14/13, at 8:30 a.m. nursing assistant (NA)-B was observed to wash and dry the resident's face. No attempts were made to encourage the resident to do this for himself. During the observation, the resident's toe nails were observed to be very long, darkened in color and curved to the right. NA-B acknowledged the observation and indicated the nursing staff was to check them weekly when the resident had a bath and nursing staff was to cut them as needed. During observation of morning personal cares on 8/16/13, NA-J was observed to wash and dry R68's face. No attempts were made to encourage the resident to do it for himself. An interview with NA-C was completed on 8/16/13, at 10:03 a.m.	F 311	**F 311** 1. Corrective Action: A) Resident #68 has been reassessed and his ADL needs were revised. His care plan and care sheets were updated to reflect the need to encourage/allow him to perform his ADL's as independently as possible. He was also referred to a podiatrist to have his toe nails trimmed. 2. Corrective Action as it applies to other residents: A) All residents have the potential to be affected by the same deficient practice. B) The care standards were reviewed and nursing staff were provided education on the expectation that they will encourage/allow independence with ADL's and that they will either provide nail care to all residents or assure that the podiatrist is contacted when the residents nails cannot be trimmed by facility staff. 3. Date of Completion: 10/3/13	

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 311	Continued From page 141 NA-C indicated that assisted R68 occasionally and when she cares for the resident, and she washed him, as she had been told that he refused to wash his own face. The plan of care, initiated on 10/8/12, noted a deficit of self-care related to the resident's impaired mobility and weakness. An established goal was for R68 to continue to wash and dry his face and hands after the staff set up his personal care items. The approaches specified staff were to encourage the resident to wash and dry his face and hands and they were to assist as necessary. The care plan also noted the potential for alteration in skin integrity and the skin would remain free of pressure ulcers. The problem area was developed 7/26/13. The interventions directed staff to observe the feet and skin with cares and refer to a podiatrist as needed. A significant change Minimum Data Set (MDS) was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. He needed extensive assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene. The Care Area Assessments (CAAs), completed on 7/12/13, noted that the resident had been hospitalized from 6/11/13 to 6/14/13, and although there were some areas of improvement a significant change MDS was completed as it was determined he had declined overall and due	F 311	4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. Completion will be monitored by: The Director of Nursing or Designee	

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F 311	Continued From page 142 to his potential for skin breakdown, continued need for assistance with transfers and the potential/expectation he would continue to have variations in mobility. It was also documented his status was variable related to his medical condition, dialysis, fragile status and periods of increased weakness. The undated Nursing Assistant Assignment Sheet instructed one nursing assistant to assist resident with dressing and grooming and did not identify the need to encourage R68 to remain independent. The Nursing Assistant Assignment Sheet did not given any instruction regarding foot (nail) care. An interview with licensed practical nurse (LPN)-D was completed on 8/15/13, at 9:30 a.m. She reported was aware that R86's toenails were very long but she was not responsible for cutting them, as he was diabetic. She indicated the resident would need to be seen by a podiatrist, who would address the length of his toenails. She reported she did not know if he had been seen by the podiatrist. An interview with registered nurse care manager (RN)-A on 8/15/13, at 10:15 a.m. was completed. She reported she was unaware of R68's toenails being long. She reviewed the medical record and then reported she did not believe the podiatrist had seen the resident and R68 should have been seen. She indicated the condition of resident's toes nails should be monitored every two weeks and if there was an issue, there should be documentation of this in the medical record. She reported no documentation was found. An interview with the director of nurses (DON) on	F 311		

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F 311	Continued From page 143 8/16/13, at 4:10 p.m. was conducted. The DON reported the plan of care should have been followed and he should have been referred to the podiatrist for care of his feet. The undated policy Activity of Daily Living, did not address foot care or involving resident in performing personal cares.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R35, R17, R42) received assistance to complete activities of daily living (ADLs). Findings include: R35 was not provided grooming assistance with shaving and nail care on 8/12/13, 8/13/13 and on 8/14/13. On 8/12/13, at 4:41 p.m. during observation and interview, R35 was observed to be lying in bed and to have approximately one to two days growth of beard. R35's fingernails were long (approximately a quarter inch past the tips of the fingers) and had a dark colored debris under the nails of both hands. R35 initially stated he liked to	F 312		

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F 312	Continued From page 144 cut his own nails because he liked to do his own cares when he could. R35 stated he had a "safety razor" and pointed to the over bed table. An electric razor was observed to be on the over bed table. On 8/13/13, at 1:23 p.m. R35 was randomly observed to be up in his chair, then was transferred to his bed by two facility staff and a mechanical lift. R35 was observed to have many days growth of beard, his fingernails remained soiled and long. On 8/14/13, R35 was continuously observed from 7:30 a.m. until 10:25 a.m. - At 7:30 a.m. although R35's shower day was scheduled for 8/13/13, the clinical record lacked evidence the shower was refused. R35 was observed to be many days unshaved, the fingers on both hands had brownish/black debris under approximately quarter inch long nails. R35 was already dressed and laying on top of the bed covers. - At 7:50 a.m. two nursing assistants (NA)-H and NA-A entered R35's room with a mechanical lift. - At 7:53 a.m. R35 was observed to be transferred to the wheelchair. R35's hair was combed and R35 was immediately wheeled to the dining area. At the time of the observation, an unplugged rechargeable electric razor was observed on the overbed table next to the bed. A near empty can of shaving cream, a bottle of powder, an open package of wipes were observed on the bed side stand. - At 8:01 a.m. R35 was observed to be sitting in his wheelchair in the dining room at the table. When asked when he received his morning cares, R35 stated he was dressed at 6:30 a.m. and was then left in bed. When asked if staff had	F 312	**F312** 1. Corrective Action: A) Resident #35 has been shaven and nail care has been provided. B) Resident #17 has been shaven. C) Resident #42 has been provided nail care. 2. Corrective Action as it applies to others: A) All residents have the potential to be affected by the same deficient practice. B) The care standards were reviewed and nursing staff were educated on the expectation to routinely provide shaving and nail care to residents who are not able to independently perform these tasks. 3. Date of Completion: 10/3/13 4. Recurrence will be prevented by:	

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F 312	Continued From page 145 offered to assist him with shaving, R35 stated he discussed shaving with the staff yesterday, "They told me they'd try to shave me, but the razor wasn't charged. They need to plug in the razor." When asked if nailcare was offered, R35 denied it was offered. - From 8:01 a.m. until 9:13 a.m. R35 remained in the dining room for breakfast. - At 9:13 a.m. R35 completed the breakfast meal and pushed himself away from table. NA-H transported R35 out of the dining room and to his room. NA-H moved the overbed table within R35's reach. R35 sat at the bedside in the wheelchair. The razor remained on the overbed table and remained unplugged. - At 9:24 a.m. R35 verified the razor on the overbed was his personal razor and it had no power. R35 picked up the razor and pushed the on button, the razor did not operate. - At 9:27 a.m. R35 was transferred back into bed with the mechanical lift by NA-H and NA-A. - At 9:35 a.m. NA-A stated she was completed with all R35's grooming and washing needs. NA-A stated R35 "shaves himself" and stated he used an electric razor. NA-A confirmed the razor at the bedside was for R35, attempted to turn the razor on and confirmed the battery charge was dead. NA-A stated the razor needed to be charged and asked R35 where the charger cord was located. R35 pointed to the top drawer of the bedside table. NA-A found the charger and plugged in the razor. NA-A stated she did not look at R35's nails during his cares, and confirmed they were long and soiled on both hands. - At 10:34 a.m. the licensed practical nurse (LPN)-H explained shaving should be completed as needed and on shower day. LPN-H explained nailcares were completed by the nurse on shower day and NA staff should report to her if the nails	F 312	A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. Completion will be monitored by: Director of Nursing or Designee	

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F 312	Continued From page 146	F 312		

were long, needed trimming or were soiled. LPN-H stated R35's long and soiled nails were not reported to her. LPN-H stated the razor should have been plugged in by the NA staff for a charge; R35 "trys to shave himself," but "misses a lot" and NA staff need to offer to assist and shave the "patchy areas."
- At 10:25 a.m. both NA-H and NA-A verified R35 was not offered the opportunity to shave, the long nails were not reported to LPN-H, verified the razor was visible and not charged.

R35's care plan dated 3/15/10, identified deficits with shaving, low motivation, and fatigues easily. The care plan directed to provide total assistance and included a hand written note dated 2/12 - "Res. [resident] wants to be shaved." and directed, "Assist of 1 to shave w/ Electric razor daily or PRN [as needed]." The care plan further directed, "Nail care & skin check on bath day."

The Diagnoses Report - Clinical dated 3/31/11, indicated R35 had the following diagnoses: diabetes mellitus type II, peripheral neuropathy, gout, obesity, dementia, pre-glaucoma, and depression with anxiety.

The quarterly Minimum Data Set (MDS) dated 5/14/13, indicated R35 had a Brief Interview for Mental Status (BIMS) score of 13 (mild impairment). The MDS indicated R35 was non-ambulatory, required total assistance with transfers and toilet use; extensive assistance with bed mobility, locomotion, eating, dressing and personal hygiene. The MDS identified R35 had impairment in both lower extremities.

A Nurse's Note for R35 dated 8/13/13, written at 10:50 a.m. indicated, "Refused to be shaved by

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F 312	Continued From page 147 NAR [nursing assistant registered] unable to verbally redirect. States, 'I wanna shave when I get my shower.'" The undated Nursing Assistant Assignment Sheet AM/PM identified R35's bath was on Tuesday (8/13/13) evening did not address nail care and did not address shaving. The sheet indicated, "Demanding--verbally abusive when care not provided when he wants it done. Report non-compliance with cares to nurse." On 8/19/13, at approximately 1:30 p.m. the director of nursing (DON) verified R35 should have been offered the opportunity to shave and the need for nail care should have been reported to the LPN for diabetic nail care. R17 was observed to have facial hair on her lower chin on 8/12/13, 8/13/13, 8/14/13 and 8/15/13, and was not provided with assistance to remove the facial hairs. The significant change MDS dated 6/24/13, identified R17 had dementia, hemiplegia, required extensive assistance with ADL's. The Care Area Assessment (CAA) for ADL Functional Status/Urinary Incontinence/Pressure Ulcers/Falls dated 6/29/13, identified R17 received extensive assistance with ADL's as needed (dressing and grooming) & assistance with hair/wig. The care plan dated 7/8/13, identified R17 had, "Self-care deficits related to impaired mobility, weakness & cognitive impairment -left sided hemiplegia." The care plan further indicated R17 received assistance with dressing, grooming and bathing. R17 care plan focus goal identified she,	F 312		

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F 312	Continued From page 148 "Will be neat, clean & odor free." On 8/12/13, at 5:39 p.m. R17 was observed lying in her bed on her back with numerous facial hairs to the lower chin (approximately a half (1/2) inch in length) down her front neck area. On 8/13/13, at 10:00 a.m. observed facial hairs still not removed. On 8/13/13, at 12:23 p.m. family (F)-A stated R17 had always had the facial hair and was not sure how she felt about it. F-A further stated other family relatives including F-A usually brought to the facility shaving cream and razor and assisted R17 to take the facial hair off but no specific frequency provided when family came to assist resident. On 8/14/13, at 8:09 a.m. to 9:30 a.m. during continuous observations: -At 8:09 a.m. to 8:14 a.m. observed R17 up in her wheelchair in her room dressed in a yellowish-green and red print dress. R17 gestured at surveyor to assist her with her wrist bracelet but NA-F assisted resident then left the room. -At 8:15 a.m. NA-G observed entering R17's room and brought resident to dining room. R17 still observed to have several facial hairs to lower chin and down the neck area. -At 8:19 to 8:23 a.m. NA-G observed to offer R17 and other residents at the dining room wipes to cleanse hands before breakfast. -At 8:24 a.m. observed NA-G offered R17 clothing protector and applied it facing R17 from the front. -At 8:25 to 9:30 a.m. R17 was observed in the dining room eating her breakfast, observed several staff came up to resident including NA-F	F 312		

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F 312	Continued From page 149 & NA-H and no staff offered to remove facial hair. -At 9:31 a.m. NA-F came and picked resident from the table and took R17 to her room, shut the door and then came out observed to be carrying a plastic bag and went to the soiled utility room. On 8/14/13, at 9:42 a.m. observed R17 lying in her bed with facial hairs still there and visible. On 8/14/13, at 12:15 p.m. observed R17 sitting in the dining room table waiting for lunch observed to still have facial hairs. Again several staff in the dining room area no one offered to remove the facial hair for resident. On 8/14/13, at 1:51 p.m. interviewed NA-F went to resident room with LPN-B to verify but R17 was not in the room. NA-F explained to nurse and surveyor that she had assisted resident with dressing, applied lotion, applied socks and shoes for her after washing up. NA-F stated that she also had assisted R17 to the toilet and set her up to brush her teeth and helped to clean up after and had left the room. Not at any time during the interview NA-F mentioned she had removed resident facial hairs for R17. On 8/15/13, at 8:30 a.m. observed R17 in the dining room table eating breakfast still had the facial hairs. On 8/15/13, at 10:43 a.m. observed resident in the ground level being assisted by a staff to get into the elevator still had facial hairs. On 8/15/13, at 2:00 p.m. LPN-B verified that R17 had numerous facial hairs on her lower chin and neck area, stated her expectation was staff to offer residents to remove facial hair daily and as	F 312		

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F 312	Continued From page 150 needed when they see it immediately. On 8/16/13, at 9:21 a.m. interviewed registered nurse (RN)-A and LPN-A regarding the facial hair, RN-A stated the, "Facility does not have a facial hair removal policy but once a week staff go around and ask to remove resident's facial hair. Staff was to follow up and re-approach resident if resident refused, it's their right to do so then nursing assistants have to report to the nurse to document the refusal." On 8/16/13, at 1:03 p.m. interviewed the consultant director of nursing (O)-D stated her expectation was staff to remove the facial hair for the resident's daily and as needed as this was a dignity issue especially for female residents. O-D reported all staff was supposed to continue to re-approach if a resident refused and report to nurse if not able to assist the resident with cares. Above all staff had to follow each resident's plan of care directed by the care plan. R42 was observed to have long finger and toenails 8/15/13, 8/16/13 and 8/19/13. During observation of cares on 8/16/13, at 9:24 a.m. R42's toenails were noted to be ½ inch long. The self-care deficit in bathing care plan dated 4/6/09, directed nail care to be done on bath days. The potential for abrasion due to scratching self-care plan dated 5/13/10, directed nails will be trimmed every week. The quarterly MDS dated 6/20/13, indicated R42 had severely impaired cognitive skills for daily decision making and required total assist with	F 312		

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F 312	Continued From page 151 personal hygiene. On 8/15/13, at 2:13 p.m. R42's nails were noted to be ¼ inch long, LPN-D stated she usually cut R42's nails on bath day or when she notices they are long. The bath log was reviewed and indicated R42 received baths on Wednesday evenings. When interviewed on 8/15/13, at 2:31 p.m. NA-M verified R42 received a bath on 8/14/13. When interviewed on 8/19/13, at 11:14 a.m. LPN-H verified R42's nails were long and stated the nurses cut R42's nails with baths.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions on the plan of care to minimize skin breakdown for 1 of 1 resident (R42) reviewed for pressure ulcers. This practice resulted in actual harm for R42 who acquired three new pressure ulcers while in the facility.	F 314		

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F 314	Continued From page 152 Findings include: R42 had a history of recurring pressure ulcers and was not repositioned for three hours and 33 minutes on 8/15/13. The plan of care was not revised and/or followed to promote healing of the Stage 2 ulcers (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). On 8/15/13, from 8:10 a.m. to 10:33 a.m. R42 was observed sitting in a wheel chair in her room without being repositioned. Nursing assistant (NA)-I and trained medication aide (TMA)-B entered R42's room and assisted her into bed. When asked, NA-I stated she had gotten R42 up in the wheel chair at 7:00 a.m. (a total of three hours and thirty-three minutes) and she repositioned R42 every two hours in the wheel chair. R42's buttocks were visualized during cares and an open area was observed on each buttock. A white colored ointment was noted to the open areas and no other dressing was present. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed. At 9:24 a.m. NA-I verified R42 was lying on her back in bed. On 8/16/13, at 2:01 p.m. R42's buttocks were observed with licensed practical nurse (LPN)-A and the consultant nurse. The consultant nurse stated the coccyx area was open and measured the area as 2.2 centimeters (cm) x 0.3 cm. LPN-A stated the coccyx was "probably just open from sitting in the chair." A 1 cm x 1 cm dark red area was noted to the right buttock. The nurse	F 314	**F 314** 1. Corrective Action: A) Resident #42 was reassessed and a new Skin assessment was completed to determine repositioning needs while in bed. Preventative measures to promote healing of her ulcers were reviewed and revised. Her care plan and care sheet were reviewed and revised. The physician has been updated on the condition of the wounds. 2. Corrective Action as it applies to others: A)All residents with pressure ulcers have the potential to be affected by the same deficient practice. B) The Pressure Ulcer/Skin Care Policy has been reviewed and revised. C) Nursing Staff members have been educated on the Pressure Ulcer/Skin Care Policy and the need to follow the individualized orders and care plans for treatment of wounds and pressure relief measures, including turning/repositioning and off-loading pressure. 3. Completion Date: 10/3/13	

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 314	Continued From page 153 consultant stated the area to the right buttock was not open, was just fragile. After returning to the nursing station, LPN-A told LPN-D to get a Duoderm (a hydrocolloid dressing) order for R42. The left buttock was noted to have scar tissue from prior pressure ulcers. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed. Physician's Order dated 9/27/12 and 1/4/13, directed staff to off load the resident from the wound, and to limit sitting to 60 minutes. The physician's order dated 1/4/13, indicated R42 had right and left buttock wounds. A Wound Care Specialist Evaluation (WCSE) dated 1/2/13, indicated R42 had Stage 2 pressure ulcers to the right and left buttocks. A WCSE dated 1/9/13, indicated the pressure ulcers to both buttocks had resolved. A WCSE dated 2/6/13, noted R42 had a Stage 2 pressure wound of the left buttock. A WCSE dated 2/13/13, noted R42 had Stage 2 pressure ulcers to the right and left buttock and recommended "limit sitting to 60 minutes." A physician's Progress note dated 1/17/13, noted R42 had sacral area decubitus, one on the right buttock and one on the left buttock which required care and offloading. The care plan for skin integrity was not revised for the physician's orders of limiting sitting to every 60 minutes and the NA assignment sheet was not updated. The Weekly Wound Documentation Progress Sheets (WWDPS) were requested for R42. A WWDPS dated 4/24/13, indicated R42 had a Stage 2 pressure ulcer to the right sacrum which	F 314	4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. Completion to be monitored by: Director of Nursing or Designee	

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F 314	Continued From page 154 was noted as healed on 5/8/13. A WWDPS dated 8/1/13, indicated R42 had one Stage 2 pressure ulcer to the right buttock which was noted as healed on 8/14/13. No other WWDPS were provided. A Worksheet for Skin Checks over Bony Prominences-Lying and Sitting was completed on 3/16/13, and indicated no redness after two hours. An additional assessment was not completed when R42 was identified as having multiple open areas on 7/29/13. R42's Care Area Assessments (CAAs) for the annual MDS dated 3/20/13, were requested and were not provided. A Braden scale (an assessment used to determine pressure ulcer risk) dated 6/14/13, noted R42 was at very high risk for skin breakdown. A Pressure Point Assessment dated 6/16/13, indicated R42 had pressure present at the sacrum, heels and ear. R42's quarterly Minimum Data Set (MDS) dated 6/20/13, revealed R42 had severely impaired cognitive skills for daily decision making, required total assist of two staff for bed mobility, transfers and toileting, and was at risk for pressure ulcers and had no pressure ulcers present. The MDS did not indicate the R42 had pressure present at the sacrum, heels and ear. A Nurse's Notes dated 7/26/13, noted the nurse practitioner was, "Notified of breakdown on bottom on (L) [left] & (R) [right] cheek (inner) [unclear] breakdown to area, 2 new O/A's (L) cheek 5 cm L [long] 3 cm W [wide] and (R) cheek 3 cm x 3 cm L."	F 314		

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F 314	Continued From page 155 A skin integrity care plan dated 7/29/13, indicated open area to buttocks and directed reposition side to side with no back lying, and Duoderm to open area on buttocks Stage 2. The area was noted as resolved 8/14/13, and the Duoderm was restarted 8/16/13. The care plan directed staff to reposition R42 every two hours. The care plan was not revised to reflect the physician's order of 1/3/13 to limit R42's sitting up for 60 minutes. A nurse practitioner note dated 7/29/13, indicated R42 had two open skin areas to the left buttock which measured approximately 3 cm X 2.5 cm and 3 cm x 1 cm with superficial depth that was not measurable and two areas on the right buttock which measured 3 cm x 2.5 cm and 2.5 cm x 1 cm. Physician's orders dated 7/29/13, directed "1) Cleanse with normal saline 2) pat dry, 3) skin prep to intact peri wound skin, 4) Duoderm dressing every 3 days and as needed to stage 2 wound on buttocks" and "1) [wound doctor] to see (wounds on buttocks) Turn, reposition, side to side, every 2 hours, no back lying (wounds on buttocks) 2) Air mattress (multiple wounds on buttocks)." A physician's order dated 8/14/13, directed "Calmoseptine Ointment [multipurpose moisture barrier] apply topically to excoriated/irritated areas on buttocks perineum with incontinent pad changed 3 times daily (skin integrity)." The Nursing Assistant Assignment Sheet received on 8/15/13, directed toileting assist of one every two to three hours check and reposition, up for two hours AM/PM and position side to side every two hours, remain off back	F 314		

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F 314	Continued From page 156 when in bed. The assignment sheet conflicted with the care plan that directed staff to reposition R42 every two hours. A Nurse's Note dated 8/16/13, at 1:00 p.m. indicated R42's buttocks were open and a message was left with the nurse practitioner to update regarding applying Duoderm. A Nurse's Notes dated 8/16/13, at 2:10 p.m. noted R42's coccyx area has 2.3 cm x 0.3 cm area on buttock. When interviewed on 8/14/13, at 2:13 p.m. LPN-D stated R42 should still be getting Duoderm to the pressure sores on the buttocks. When interviewed on 8/16/13, at 2:21 p.m. LPN-A stated R42 only had open areas to the right buttock and the open area (o/a) to the coccyx was new. When interviewed on 8/16/13, at 2:39 p.m. LPN-D stated both the coccyx and the right buttock were open but she did not measure them. When interviewed on 8/16/13, at 2:21 p.m. the registered nurse consultant only confirmed the coccyx was opened. No further comment was offered. The facility's Pressure Ulcer And Associated Skin Problems Policy and Procedure and signed 3/26/09, directed staff to position the resident off the affected area if there was a Stage 2 pressure area.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315		

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F 315	Continued From page 157 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting for 1 of 3 residents (R82) reviewed for urinary incontinence. Findings include: The Resident Status Summary dated 11/21/12, noted R82 was continent of bowel and required extensive assist of one staff for toileting. R82 was not assisted to the toilet for three hours and forty-one minutes. During continuous observations on 8/16/13, from 7:40 a.m. until 11:21 a.m. R82 was observed sitting in a chair in the dining room on second floor without being assisted to the toilet. At 11:21 a.m. nursing assistant (NA)- L was asked to assist R82 to the toilet. NA-L stated she had asked R82 if she wanted to use the toilet earlier and R82 had refused. NA-L approached R82 and asked her if she needed to go to the bathroom. R82 did not respond to NA-L's question. When NA-L was asked what she would do if R82 does not respond to her toileting prompt, NA-L stated she would tell the nurse. At 11:35 a.m. NA-L reported to licensed practical nurse (LPN)-D she was unable to assist R82 to the toilet. LPN-D did	F 315	F315 1. Corrective Action: A)Resident #82 has been reassessed for her toileting needs. Her care plan and care sheet was updated to reflect her needs. Nursing staff members have been educated on the need to toilet her according to the care plan and to provide incontinence care and pad changes as the need arises. 2. Corrective action as it applies to others: A) All residents who experience incontinence and/or need assistance with toileting have the potential to be affected by this deficient practice. B) The Bowel and Bladder Policy was reviewed and revised as appropriate. C) Nursing staff members were educated on the need to follow the care plan and care sheets in order to meet the toileting needs of the residents. 3. Date of Completion: 10/3/13	

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F 315	Continued From page 158 not respond to NA-L or assist R82 with her toileting needs. NA-L did not re-approach R82. R82's significant change in status Minimum Data Set (MDS) dated 7/5/13, revealed R82 had severely impaired cognitive skills for daily decision making, required extensive assist of one for toileting and was frequently incontinent of bowel and bladder. The Care Area Assessment (CAA) for urinary incontinence dated 7/5/13, indicated R82 had decreased wetness/incontinence episodes with toileting every two hours during waking hours. The impaired bowel and bladder function care plan dated 7/11/13, noted R82 was on a toileting program which decreased bowel incontinence. The care plan directed staff to check resident every two hours and provide incontinence cares/pad changes as needed. The care plan directed staff to assist of one with toileting as needed and if resistive to cares, re-approach with another staff person/assist of two as needed. A Goal Analysis Noted dated 7/11/13, indicated R82 " is now toileted & not prompted, toileting program has changed." Upon interview on 8/16/13, at 1:03 p.m. the director of nursing stated she expected residents to be toileted according to the plan of care.	F 315	4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. Completion will be monitored by: Director of Nursing or Designee	
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase	F 318		

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F 318	Continued From page 159 range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure range of motion (ROM) plans were developed and implemented; splints, braces and AFO (adaptive foot orthotic) devices were applied as ordered by the physician for 4 of 4 residents (R45, R35, R42, R23) in the sample reviewed for ROM. Findings include: R45's Resident Admission Record dated 9/19/12, indicated R45 was admitted with diagnoses to include vascular dementia, dysphagia, muscle spasms, osteoporosis, persistent mental disorder, pain, depressive disorder, hypertension, and left hemiplegia. was not consistently offered or provided with a left hand splint, a left elbow brace or a left AFO. In addition, the facility failed to develop a ROM plan to prevent potential decline of a left hand contracture. R45 was observed to have a contracture to the left hand on 8/12/13, at 3:48 p.m. R45 was observed to have left sided weakness and was not wearing a splint to the left hand. On 8/13/13, at 1:12 p.m. the licensed practical nurse (LPN)-C stated R45 had an AFO for the left ankle to be applied in the morning and removed in the evening, a left elbow sling on in the morning and off in the evening. LPN-C stated the AFO was "care planned as refused." LPN-C	F 318	**F318** 1. Corrective Action: A)Resident #45 has been reassessed for splint/ AFO brace needs. The equipment has been cleaned. He was assessed for a ROM program to prevent ULE and LLE contractures and his care plan reflects his current needs. B)Resident #35 was reassessed for ROM, splint/brace and foot guard (on his w/c) needs. His care plan was reviewed and revised to include what to do if the resident refuses ROM, brace or foot guard application. C)Resident #42 is being reassessed for splint and palm protector needs has current therapy order. D) Resident #23 was reassessed for ROM and ambulation needs and the care plan were updated.	

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F 318	Continued From page 160 stated R45 had a contracture of the left side elbow and hand. Observations on 8/12/13 thru 8/14/13, R45 did not wear a hand splint, elbow splint or AFO at any time. On 8/14/13, the following was noted: - At 1:53 p.m. while interviewing R45 in his room, a sheep skin hand splint was observed to be in the opened top drawer of the bedside stand. R45 stated he was supposed to wear the splint "all the time." R45 stated he did not apply the splint himself and he needed the staff to apply the splint. R45 stated the nursing assistant (NA) staff " usually forgets" and he calls to remind them to apply the splint. R45 stated the NA staff did not offer to assist him and he expressed he "shouldn't have to ask." R45 was unclear if he received ROM, denied wearing an elbow splint and stated the AFO was "in the closet." - At 1:55 p.m. NA-H stated she usually asks R45 if she can apply the splint, and if R45 allows, she will apply it, "But we cannot force it." NA-H stated the splint could be applied "anytime" and R45 should wear it as much as possible. NA-H verified the splint should have been applied, but restated, "We cannot force him." NA-H stated R45 usually refused to wear the elbow splint and AFO. NA-H stated R45's ROM should be done with application of the braces or splints. NA-H was unclear what kind of ROM was provided, such as passive or active and was unclear on how many repetitions of the ROM should be provided. - At 1:59 p.m. LPN-H stated the splint should have been applied and if R45 refused the splint, it should have been reported. LPN-H stated the refusal to wear the splint was not reported to her and explained the splint was to treat R45's contracture. LPN-H stated if R45 refused	F 318	2. Corrective Action as is applies to others: A)All residents in need of splints/braces, ROM, and ambulation have the potential to be affected by these deficient practices. B)The Restorative Nursing Policy was reviewed and Nursing Staff members were educated on the need to complete the programs as ordered and document routinely. 3. Date of Completion: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning. 5. Corrections will be monitored by: Director of Nursing or Designee	

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F 318	Continued From page 161 cares/treatments, staff should report it, and she would explain risk benefits to R45. LPN-H stated risk and benefit education should be documented in the nursing notes. LPN-H confirmed R45 did not wear the AFO or elbow splint consistently, but was unclear if R45 received ROM. - At 2:13 p.m. the door to R45's room was observed to be partially open. NA-K and NA-H knocked on the door and entered R45's room. R45 was observed to be ambulating independently in his room with a quad cane. He was not wearing the splint, elbow brace or AFO. His left foot was observed to be flaccid and make a flopping sound with each step. His wheelchair (W/C) was near the door. NA-H asked R45 repeatedly, "Where is your arm rest? Where is your arm rest?" and began searching R45's room. R45 kept asking, "What? My arm rest?" When both NA staff began looking through a drawer of the dresser near the door, R45 then stated, "Why are you going through my stuff?" NA-H stated, "We're looking for your arm rest. Then we will go for your walk after report." Once it was determined the NA staff were looking for R45's splint, R45 stated the splint was in the open top drawer of the bedside table (visible to both staff as they searched the room). NA-K retrieved the splint, applied gloves and discussed with R45 that he "can refuse" the splint. NA-K then applied the splint to the R45's left hand. R45 allowed the splint application and denied discomfort. NA-K stated the left hand was cleaned daily, but was unclear when the splint was last cleaned. NA-K verified the splint was soiled from past use. The annual Minimum Data Set (MDS) dated 9/25/12, indicated R45's a Brief Interview of Mental Status (BIMS, a tool used to measure cognition) score could not be completed and	F 318		

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F 318	Continued From page 162 identified R45 had short and long-term memory impairments; R45 required limited assistance with walking and transferring; R45 had both upper and lower functional limitations on one side of his body. The Cognitive Loss/Dementia-Care Area Assessment (CAA) dated 9/25/12, identified R45's cognitive losses and that R45 was not independent with decision making skills, that R45 was inattentive, had disorganized thinking, physical behaviors towards others and rejection of cares. The Activities of Daily Living (ADLs) Functional Status/Urinary Incontinence/Pressure Ulcers CAA identified R45 had impaired mobility, spasticity, left Hemiplegia, and contracture of his left hand. The CAA further indicated, "He will occasionally refuse to wear his left hand splint & LLE [lower left extremity] AFO." Although the CAA identified R45 had a contracture and occasionally refused the splint and AFO, the CAA did not identify the left elbow brace and did not identify a ROM plan. The care plan for self-care deficit dated 10/9/12, identified R45 had impaired mobility, spasticity, left hemiplegia, contracture of left hand and cognitive impairment. The care plan identified, "He will occasionally refuse to wear his Left hand splint & LLE AFO." The care plan did not address ROM and did not identify interventions to address R45's refusals. The care plan did not identify use of or refusal of the left elbow brace. The Occupational Therapy Discharge Summary dated 2/1/13, indicated was evaluated to address positioning in W/C for R45 to be able to self-propel within facility safely. The summary indicated was R45 was discontinued from therapy	F 318		

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F 318	Continued From page 163 due to refusals. The April 2013 through August 2013, Medication Administration Record (MAR) and Treatment Administration Record (TAR) included the left hand splint, left elbow splint, AFO brace and washing left hand with soapy water and dry twice daily (BID), ROM to left upper extremity and left lower extremity BID. The above listed items were documented as consistently applied. All splint, brace, AFO and ROM interventions were documented as applied for both shifts 8/12/13 through 8/14/13, when the above devices were observed to not be applied to R45. The MDS Note: Resident ADL Status/Summary Clarification dated 6/21/13, identified, "(hand splint) - (ROM) - (leg wraps) Wanderguard." The Occupational Therapy Evaluation dated 7/4/13, indicated R45 was seen for "Positioning for LUE [left upper extremity]." The Occupational Therapy Evaluation dated 8/5/13, indicated R45 was seen for safety & community Reintegration. Therapy notes did not address R45's use of splinting, brace or AFO devices and did not address R45's ROM. Physician's Orders dated 7/31/13, directed the staff to apply/provide: "Left Hand Splint on in AM, off at bedtime; AFO Brace to left ankle/leg on in AM, off at bedtime; Wash left hand with soapy water and dry twice daily; Range of motion to left upper extremity and left lower extremity twice daily; and Ace elastic bandage 4" wrap both legs daily PRN [as needed] to protect skin if using AFQ [sic] brace if pt [patient] allows."	F 318		

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F 318	Continued From page 164 The Nursing Rehabilitation Restorative Splint or Brace Assistance Program Daily Documentation included AFO Brace application, L hand splint, L elbow splint for November 2011 to present. The clinical record lacked evidence of the restorative program being performed. The undated Nursing Assistant Assignment Sheet AM/PM directed R45's specific care needs. The sheet directed NA staff to apply "Left palm protector" and "Left elbow splint and to apply "AFO brace to left lower extremity." The sheet further directed, "ROM to left UE [upper extremity] and LE [lower extremity] BID." Although the sheet directed to apply the devices, the sheet did not specify when to remove the devices. The sheet did not specify the type of ROM, such as passive range of motion and did not specify the number of reps and sets. On 8/14/13, at 2:35 p.m. the registered nurse manager (RN)-A stated R45 should get ROM to the left upper extremity and left lower extremity BID. RN-A stated the ROM was "usually done with cares" but could not verify the type of ROM R45 should receive. RN-A stated she thought the hand splint was brought in by the family and believed it was to be applied PRN. RN-A stated she had seen the AFO brace applied but was not clear when. RN-A was unclear if the elbow brace was applied. RN-A stated she would need to talk to therapy about the brace and stated she was unclear on what ROM was to be provided with cares. RN-A further stated, "Therapy usually makes up a binder which is placed in the closet." On 8/15/13, the following was noted: - At 2:42 p.m. RN-A confirmed the AFO was in the bottom on the right side of the closet, many	F 318		

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F 318	Continued From page 165 clothing items were observed to be piled on top of the AFO. RN-A confirmed the AFO should have been applied to R45 and confirmed there was no binder directing ROM in R45's room. RN-A was unclear where the elbow brace was and confirmed it was not in the room or on R45. - At 2:45 p.m. RN-A checked with the occupational therapist (OT) regarding the ROM the splint/brace and AFO and the OT confirmed R45 had a splint, brace and AFO ordered, as well as ROM, but was unclear when R45 was evaluated and was unclear when they were ordered. OT stated she was informed today R45 had an elbow splint ordered and confirmed she could not find it. OT was unclear on the when the AFO was ordered. OT verified R45 was at risk for further contracture development due to left hemiparesis, "Anyone with affected arm would be at risk; he would be low risk because he does a lot of his own ROM." OT stated R45 was still on case load for custom W/C seating. - At 3:08 p.m. OT stated R45 came to the facility with the hand splint and the elbow brace and they were from prior to admission to the facility. OT stated R45 was not seen by their department for function or ROM and they did not develop a program for ROM or splinting. OT stated she did not measure the contracture of the hand and confirmed there was no elbow contracture. OT was unclear if physical therapy (PT) developed a ROM program for the lower extremity or if they were aware of a plan with the AFO. OT stated she was unaware of physician's orders for ROM and was not aware of a protocol being developed for the ROM. "I don't know what nursing has for him." OT stated if there was no protocol, "One would have to be developed." On 8/16/13, at approximately 12:00 p.m. the OT	F 318		

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F 318	Continued From page 166 stated she discussed the ROM with nursing and was unclear if there had ever been ROM for R45, was unclear on the status of the splint, elbow brace or AFO. OT stated since there was no clear ROM program, she assessed R45 and was going to develop a ROM plan for him. OT confirmed again there was no measurements of R45's hand contracture, but stated she checked the hand (R45 would not allow hand check from surveyor today) and stated it "smelled" and had "a lot of moisture." OT stated the skin was intact and did not appear to have any signs of breaking down. OT verified the hand was not cleaned that day. On 8/19/13, at approximately 1:30 p.m. the director of nursing (DON) verified application of R35's braces and his ROM should have been consistently offered and completed. DON stated the facility had an "ongoing problem" with ROM and splint/brace application. DON stated the therapy department used the term "program" for applying braces and splints, but it truly "was not a program." A policy for splints, braces or other orthotic devices was requested at the time. At 3:07 p.m. the DON verified there was no policy on splint/brace or AFO application, assessment, care planning or maintenance. DON verified the splint, brace and AFO should have been applied. DON stated refusals should have been documented. DON verified R45 should have been seen by therapy and a ROM plan developed. R35 was not consistently offered or provided ROM, bilateral lower extremity leg braces and a foot guard (foot buddy) on the W/C foot pedals during observations on 8/12/13, 8/13/13 and on 8/14/13.	F 318		

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F 318	Continued From page 167 On 8/12/13, at 4:43 p.m. R35 was observed be lying in bed on his right side. His legs were both bent at approximately 90 degree angles at the knee and were crossed at the ankles. R35 confirmed he had "contractures" in both legs and stated he did not receive ROM. R35 stated he had worn a brace at one time, but stated staff did not apply it anymore. R35 was unclear when the brace was last worn. R35 denied that staff placed a pillow between his legs, as both knees were observed to be touching against each other. At 4:52 p.m. R35's immediate room environment was observed to have no brace or splints. On 8/14/13, the following was observed/noted: - At 7:30 a.m. R35 was observed to be dressed and lying in bed. His legs were observed to be bent at the knees, slightly crossed at the ankles. R35 was not wearing any braces. - At 7:50 a.m. two NA-H and NA-A entered the room with a mechanical lift. - At 7:53 a.m. R35 was observed to be transferred to from the bed to the wheelchair. Both NA's tried to place R35's feet on the foot pedals, they did not stay on the pedals and hung just off the floor and were flexed back under R35's chair and were suspended a few inches off the floor behind the foot pedals. R35's hair was combed and he was transported to the dining room. - At 8:01 a.m. R35 was observed to be sitting in the W/C in the dining room at a table. R35 stated he was dressed at 6:30 a.m. and left in bed. - At 8:09 a.m. R35 stated the chair did not fit him. R35 confirmed his feet "dangled" between and behind the foot pedals and stated the foot pedals "didn't fit the wheelchair." R35 denied being offered ROM. R35 was asked again about the braces, R35 stated he remembered braces in the	F 318		

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F 318	Continued From page 168 past for his legs, but stated, "They didn't work." R35 denied that staff offered to apply the braces or that he had refused the braces. - From 8:09 a.m. through 9:13 a.m. R35 remained at the table for breakfast in the dining room. - At 9:13 a.m. R35 completed the breakfast meal, pushed himself away from table and NA-H transported R35 out of the dining room and to his room. - At 9:27 a.m. R35 was transferred from the W/C to the bed. - At 9:35 a.m. NA-A stated she was completed with all R35's grooming and washing. NA-A stated she would come back and check R35's incontinence brief and change him every two hours. - At 10:34 a.m. the LPN-H stated ROM was done with cares and stated the braces were often refused by R35. LPN-H stated neither the braces nor ROM were reported as refused to her. - At 10:25 a.m. both NA-H and NA-A were asked about ROM and the braces. Both stated R35 had braces for his legs, but stated he refused them, would remove them and throw them on the floor. The NA's stated ROM was only provided when they used to apply the brace. Both verified ROM and the braces were not offered to R35. Neither NA were able to state how much ROM to provide, such as number of repetitions and were not clear on the type of ROM to provide for R35 (such as passive ROM or active assistive ROM). The care plan for Alteration in mobility dated 3/15/10, indicated R35 had a "hamstring stretch program" daily, directed to set up for the program starting 10/4/10. A hand written update directed, "Bilateral leg splints on 1 hr [hour] after meals when in bed." [Undated] An update dated 7/16,	F 318		

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F 318	Continued From page 169 "Refusing leg splints throws on floor." A note dated 6/12/13, "Pt refuses leg gard [sic]" (leg gard [sic] on w/c behind foot pedals added 7/12. The care plan did not address the use of ankle splints. The Diagnoses Report - Clinical dated 3/31/11, indicated R35 had the following diagnoses: diabetes mellitus type II, peripheral neuropathy, gout, obesity, dementia, pre-glaucoma, and depression with anxiety. The comprehensive MDS dated 2/13/13, indicated R35's BIMS score was 12, identified no changes with ADLs. The MDS identified impairment in both lower extremities. The quarterly MDS dated 5/14/13, indicated R35 had a BIMS score of 13 (mild impairment). The MDS indicated R35 was non-ambulatory, required total assistance with transfers and toilet use; extensive assistance with bed mobility, locomotion, eating, dressing and personal hygiene. The MDS identified impairment in both lower extremities. The CAA for ADL's/Urinary Incontinence/Pressure Ulcer dated 2/27/13, indicated R35 was totally dependent on staff for grooming, bathing and dressing. The CAA indicated, "He is assisted with all ADLs & mobility as needed." The Physician's Orders dated 7/28/13, directed to apply knee splints to both legs. The splints were to be put on for one hour after breakfast and lunch; Ankle Splints both heel/elbow boots were to be applied starting at 2:00 p.m. thru the morning during sleep hours. On 8/1/13, the physician had ordered Range of Motion Program. The order first directed, "PROM Program - AM & PM During Daily Care (While in	F 318		

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F 318	Continued From page 170 Bed)." Then the order directed, "Range of Motion Program In AM & PM During Daily Cover. Complete Program While in Bed AM & PM." The undated NA Assignment Sheet AM/PM directed NA staff to apply R35's bilateral knee braces on as directed by the care plan, directed to complete "Hamstring stretch daily," to apply a "foot hugger plate" on the wheelchair. The sheet indicated, "Demanding - verbally abusive when care not provided when he wants it done." and, "Report non-compliance with cares to nurse." The TARs for June, July and August 2013 were reviewed. The following was noted: -The June 2013 TAR directed staff to complete "PROM [passive range of motion] twice daily while in bed. The TAR indicated knee splints were documented daily (even though directed to apply twice daily). The ankle splints were documented as applied twice daily. - The July 2013 TAR indicated out of 62 opportunities, the knee splints were circled as refused 25 times. The splints were not documented 12 times. The ankle braces were circled as refused 4 times and not documented three times out of 31 opportunities. The ROM was documented by the licensed nurse as given twice daily. - The August 2013 TAR directed to apply the knee splints for one hour after breakfast and lunch. The splints were documented as a circle, indicating refused 12 of 15 opportunities. The splints were only offered once daily in August. The ankle splints both heel/elbow boots starts 2:00 p.m. not signed at all for the month of August. The ROM program in AM and PM was signed off as given twice daily.	F 318		

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F 318	Continued From page 171 Review of the Nurse's Notes for R35 indicated the following: - On 8/3/13, at 6:30 p.m. a note indicated, "Resident refused heel and elbow splints [R35 did not have elbow splints ordered], Resident stated, 'he doesn't need them.' Writer informed resident about the importance of wearing splints, and the positive outcomes. Resident acknowledge info, and still refused." - On 8/4/13 (no time documented), a note indicated, "Res [resident] refused to wear any of his splints stated doesn't need them any more unable to verbally redirect." - On 8/8/13, at 4:00 p.m. a note indicated, "Pt [patient] had refused splints..." - On 8/13/13, at 10:50 a.m. a note indicated, "Res also refused splints today would not allow them to be placed on @ [at] all." At 6:00 p.m. a note indicated, "Pt refused splints again today, got up for meals." - On 8/15/13, at 7:00 p.m. a note indicated, "Refuses splints to be on." Although the Nurse's Notes indicated R35 refused the splints/braces frequently, the clinical record lacked evidence R35 consistently refused the splints/braces or that R35 was re-approached to offer the braces after a refusal. The clinical record did not indicate if the splints/braces were offered to R35 on the days he was observed without the braces. Although the Nurse's notes identified refusals of the splint/braces, the clinical record did not identify R35 had refused ROM. On 8/16/13, the following was noted: - At approximately 12:15 p.m. the OT and certified occupational therapy assistant (COTA) stated R35's bilateral knee contracture measurements were 30-50 degrees on 3/7/13; after therapy on 4/22/13, R35's knee contracture	F 318		

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F 318	Continued From page 172 measurements were 95 degrees at on the right knee and 101 degrees on the left knee. - At 12:38 p.m. OT, COTA, and the physical therapy assistant (PTA) measured R35's knee and ankle contractures. The right knee was measured at 94 degrees; the left was 98 degrees. The knee flexion measurements indicated a one degree improvement on the right knee, three degree improvement on the left. PTA stated the ankles were addressed at the time of therapy, but were identified as contracted at an angle of inversion. PTA stated the current measurements were are 67 degrees plantar flexion on the left; 60 degrees plantar flexion on the right. The PTA verified there were no measurements of the contracture to compare to. At the time of the observation, OT and COTA checked R35's closet and determined the foot guard for the W/C foot pedals was in the top shelf, along with both braces for R35's knees. The ankle braces were not observed. Both stated the guard (foot buddy) was to be applied to the W/C because R35 "has such a bad contracture" and it was intended to "prevent his feet from flexing back under the chair." Both stated R35's contracture "could be worse" without the foot buddy. While all three therapy staff was present, R35 was asked by the COTA if he would allow them to apply the braces. R35 agreed and allowed the braces to be applied. R35 tolerated application, was cooperative and denied pain or discomfort. R35 was able to state why the braces were applied "To stretch my legs out straight." Stated to the ocupational therapist/registered (OTR) he would wear the braces "for a while." Denied pain or discomfort, was pleasant. At the time of the observation, a book was observed to be hanging from the side of the closet. OT stated	F 318		

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F 318	Continued From page 173 the book was to direct the proper application of the braces to R35's legs and R35's heel float boots (ankle splints). OT stated the book was created by therapy to direct the staff through pictures and directions on how to properly apply R35's orthotics. OT verified the book did not include directions on completing ROM or a "hamstring stretch." A Nurse's Note dated 8/16/13, written at 12:50 p.m. indicated, "Res removed splints [after] 20 min [minutes]..." although R35 had the braces removed, the note indicated R35 allowed the braces to remain on for part of the time. The RehabCare PT/OT/ speech therapy (ST) Recommendations to Caregivers dated 4/18/13, indicated, "Pt has contractures on both lower extremities & needs a splinting schedule to be addressed by aides to decrease his contractures." The form directed to apply the splint after breakfast and lunch for one hour and directed to refer to the handouts in the book for proper application. A second form also dated 4/18/13, identified, "Pt has ankle contractures on both lower extremities & needs a splinting schedule to be addressed by aides." The form directed to don both heel float boots starting at p.m. shift though a.m. shift during sleeping hours. The form directed to refer to the handouts in the book for proper application of the boots. On 8/19/13, at approximately 1:30 p.m. the director of nursing (DON) verified application of R35's braces and his ROM should have been consistently offered and completed. DON stated the facility had an "ongoing problem" with ROM and splint/brace application. DON stated the therapy department used the term "program" for	F 318		

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F 318	Continued From page 174 applying braces and splints, but it truly "was not a program." A policy for splints, braces or other orthotic devices was requested at the time. At 3:07 p.m. the DON verified the facility had no policy for splint/brace or orthotic device application, assessment, care planning or maintenance. DON stated refusals should have been documented. R42 did not have splints and palm protectors applied during observations on 8/15/13, 8/16/13 and 8/19/13. During continuous observations on 8/15/13, from 8:11 a.m. until 10:33 a.m. R42 was observed sitting in a wheel chair in her room without palm protectors on. Upon interview on 8/15/13, at 10:33 a.m. NA-I verified R42 did not have palm protectors on and stated R42 did not have any splints for her legs. R42 was observed in bed on 8/15/13, at 1:49 p.m. and did not have palm protectors or knee splints on. On 8/16/13, from 7:41 a.m. until 9:24 a.m. R42 was observed lying on her back in bed with nothing in her hands. On 8/19/13, at 9:52 a.m. R42 was observed on her back in bed with nothing in her hands and no splints to her knees. At 11:13 a.m. R42 was observed sitting in a wheel chair with nothing in her hands. The potential for alteration in skin integrity care plan dated 4/6/09, directed bilateral palm protectors to hands on at all times and bilateral knee splints when in bed to preserve range of motion and maintain skin integrity. A Physician's Progress note dated 1/17/13, noted	F 318		

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F 318	Continued From page 175 R42's hands have braces because she contracts her wrist and fingers. The Patient Medical Care Plan dated 7/29/13, included a physician's order for palm protectors on at all times-may remove for cares and bathing. The Nursing Assistant Assignment Sheet received on 8/15/13, directed bilateral palm protectors and did not include direction for the knee splints. When interviewed on 8/15/13, at 2:13 p.m. LPN-D verified R42 did not have palm protectors or knee splints on. LPN-D located the knee splints in the closet and stated the NAs should be putting the splints on. LPN-D stated she thought the palm protectors were taken away and R42 was to have wash clothes in her hands. LPN-H was interviewed on 8/19/13, at 11:14 a.m. LPN-H stated R42 was supposed to have palm protectors in her hands or washcloths. LPN-H located one palm protector in the room which she applied to R42's right hand. LPN-H was unable to locate a palm protector for the left hand and stated she would have to call therapy for a new one. LPN-H stated the NAs were to apply the palm protectors after cares. R23 was not provided upper and lower extremity range of motion services as ordered by the physician and as indicated in the written plan of care. The quarterly MDS dated 6/24/13, identified R23 required extensive assistance for locomotion, both on and off the unit. The MDS indicated R23 was not steady when moving from a seated to a	F 318		

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F 318	Continued From page 176 standing position and while walking, and was only able to stabilize with human assistance. R23 was noted to have impairment on one side of the lower extremity. R23 also had functional limitations in ROM to the upper extremity functional limitations in ROM. The ADL Functional Status/Urinary Incontinence/Pressure Ulcers CAA dated 10/14/12, identified R23 required extensive assistance with bed mobility, transfers, walking in room/hall, dressing, toilet use, grooming and physical assistance with bathing. The CAA's identified R23 had impaired mobility due to cerebral vascular accident (CVA) in 2001 with right hemiplegia and related right upper extremity contracture. It identified R23 wore an AFO brace on his right lower extremity when he ambulated. The CAA's also indicated R23 had a PROM program in place as well as an ambulation program. Review of R23's care plan for physical therapy maintenance program directed resident to ambulate 20-50 feet with walker, stretching and PROM program every day. The goal was, "will complete program qd [everyday]." Current Physician Orders dated 8/5/13, directed staff to assist R23 with ambulation 20 to 50 feet with walker daily "HOLD" but was unclear when the order was put on hold as there was no documentation in the medical records during review. Review of R23's Physical Therapy Discharge Summary dated 5/14/13 to 7/10/13, revealed the following: 1. Resident met goal of bed mobility with	F 318		

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F 318	Continued From page 177 caregiver assistance 2. Resident met goal of transfers with caregiver s assistance/stand by assistance, 3. Resident does well with exercise Active Assisted Range of Motion (AAROM) right upper and lower extremity and ARROM left upper and lower extremity, 4. Resident met goal of 30 feet daily with W/C follow/ minimum assist and resident met goal of balance ... ... and floor staff had been trained and given written instructions for transfers/gait with resident and signed off on the training per documentation. Review of R23's Occupational Therapy Discharge Summary dated 5/16/13, to 6/21/13, revealed R23 presented with increased activity tolerance with graded therapeutic exercises and PROM. Education of staff for PROM restorative program for left upper extremity to decrease contracture and maintain ROM was provided. Review of R23's TAR for the ambulation program from 7/10/13 through 8/15/13, and PROM program from 6/1/13 through 8/15/13, revealed the following: 1. R23's ambulation program was on hold since 7/10/13 despite he had been discharged from therapy for restorative program. Staff circled initials from 7/10/13, through 7/31/13, and for an arrow drawn across the TAR "HOLD" for August. 2. R23's Stretching & PROM program was not completed sixty six times out of the 88 opportunities as indicated by either not being signed off or staff circled initials as not completed in the documentation. During review of signed physician telephone orders noted occupational and physical therapy	F 318		

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F 318	Continued From page 178 orders were obtained on 5/3/13, at 1:30 p.m., 5/15/13, 5/16/13, 7/10/13, 7/17/13 and on 7/18/13 a telephone order which was not in the chart during chart review but was provided later directed "Ok for PT for transfers & ambulation." The undated NA Assignment Sheet AM/PM directed "PROM-slow stretch and Ambulation per PT recommendations-PM shift." On 8/12/13, at 4:40 p.m. R23 stated he would like to walk more sometimes as the therapist and the doctor had ordered him to walk at least twice daily but sometimes he never walks. R23 further stated, he would like to be able to walk more so that he could go with family and outings like other residents in the facility. On 8/14/13, at 1:48 p.m. interviewed NA-G stated she had assisted R23 with PROM but did not know where and who was responsible to complete documentation. In regards to ambulation NA-G stated the evening shift was completing the program. On 8/14/13, at 2:12 p.m. the LPN-B stated nursing assistants were responsible to complete the PROM then report to the nurse to sign off the TAR at the end of the shift. LPN-B further stated the ambulation program was on hold as physical therapy was currently working with R23 despite physician order dated 7/10/13 that he had been discharged from therapy secondary to goals had been met. On 8/16/13, at 10:14 a.m. certified occupational therapist assistant (O)-H stated R23 had been picked up on the case load on 5/14/13, following a physician order after resident had expressed	F 318		

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F 318	Continued From page 179 desire to ambulate although original order was for a restorative program. O-H stated the original evaluation was completed on 10/28/12, for ambulation, standing, transferring and decreased functional mobility which R23 completed and was discharged on 12/07/12, from therapy. O-H stated it was later found that R23 was not being ambulated. Per O-H on 5/13/13, O-H requested an order for ambulation and safety with transfers and R23 started being seen on 5/14/13, five times weekly until 7/10/13. During the session, R23 had complained of left ankle pain after two therapists had assisted him to the floor mat in quad position for exercise on 6/4/13, an x-ray was completed no fractures and issue had resolved. O-H further added that staff was educated on resident ambulation program on 7/8/13 through 7/31/13, by physical therapy staff including the physical therapist as indicated by documentation and sign-out sheet. On 8/16/13, at 9:27 a.m. the registered nurse (RN)-A stated her expectation was to find a place to keep restorative sheets to ensure staff was documenting the PROM and ambulation after it was completed. RN-A stated also the policy was currently being reviewed and documentation would be addressed. RN-A further stated that the nurses were expected to make sure all documentation was completed by the end of their shift daily after they made sure the nursing assistants had completed the task. Later at 11:32 a.m. the consultant director of nursing (O)-D concurred with RN-A's statement. On 8/16/13, at 4:06 p.m. the O-D, RN-A and O-H stated there was a misunderstanding between the therapy and nursing departments about R23's	F 318		

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F 318	Continued From page 180 ambulation program and when it had been restarted again which explained the reason why it was not being completed. On 8/16/13, at 4:09 p.m. the certified O-H stated O-H was not aware of the order dated 7/18/13, and that had not been communicated to the therapy department at any point as resident had just been discharged from therapy 7/10/13. The ROM active and passive policy and procedure revised 8/13/13, directed staff to, "Assist the resident as necessary and assess the resident's ability to perform active range of motion. ..... ." The policy lacked a systematic procedure to ensure staff was aware who was responsible to ensure all documentation was completed and where documentation was to be completed according to the frequency ordered. Additionally, the policy lacked an on-going systematic communication channel between the therapies and nursing departments in regards to when a resident had been discharged from therapy and appropriate programs to be continued by restorative nursing.	F 318		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		

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F 323	Continued From page 181 by: Based on observation, interview and document review, the facility failed to provide adequate supervision to prevent 1 of 6 residents (R45), who was identified as an elopement risk, from unsafely eloping from the facility. Although R45 had a Wanderguard (a system used to alert facility staff when residents attempt to leave the facility) applied to his wheelchair (W/C), the facility failed to ensure the Wanderguard was functional to prevent R45 from eloping from the facility. This resulted in an immediate jeopardy (IJ) for R45 who was known to have left the facility (eloped) on 7/1/13, 7/2/13, 7/11/13, 7/29/13 and on 7/31/13. In addition, the facility failed to provide supervision that was not an IJ for 2 of 2 residents (R65, R87) to prevent potential accidents and injuries and the facility failed to develop and implement a behavioral management plan to prevent alleged abuse from occurring that was not an IJ for 1 of 1 (R8), identified as an alleged perpetrator. The immediate jeopardy began on 7/1/13, when R45 successfully eloped from the facility and was identified on 8/15/13, at 6:15 p.m. for lack of supervision of assistive devices. The administrator and director of nursing (DON) were notified of the IJ at 6:23 p.m. On 8/16/13, at 2:28 p.m. the DON was notified the IJ was removed, but noncompliance remained at the lower scope and severity level of D - isolated, scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 323	F323 1. Corrective Action: a. Resident #45 has had new wander guard placed and care plan has been updated. All staff immediately educated on wander guard system. b. Resident # 65has been discharged from facility. Resident # 87 had wander guard removed and bruises have resolved. Staff educated on transfers and monitoring of resident to resident transfers to reduce risk of bruising. c. Resident #8 has crisis plan in place, medications reviewed, family involved, and psych services working to resolve outbursts. 2. Corrective action as applies to other residents: a. All residents with wander guards have been re-evaluated for need and functioning. b. All residents with unknown incidents are	

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F 323	Continued From page 182 The clinical record indicated R45 had successfully eloped from the facility five times in the month of July on 7/1/13, 7/2/13, 7/11/13, 7/29/13, and again on 7/31/13. The clinical record lacked evidence R45's Wanderguard (departure alert system) was consistently monitored for placement and function; the nursing staff did not know where R45's Wanderguard was placed on his W/C; the facility lacked the equipment to check R45's Wanderguard for function. Although staff accompanied R45 on scheduled walks outside the facility twice daily at 10:00 a.m. and 2:30 p.m. to reduce attempts to leave the facility, the facility lacked a functional Wanderguard system to potentially prevent R45's elopements from the facility. Review of the facility's Resident Incident Reports (RIRs) from January 2013, thru July 2013 (six months), and R45's clinical record revealed the following: - On 1/6/13, at 5:55 a.m. an RIR indicated, "Res [resident, R45] - yelled for help. Was found by the door inside the SE [southeast] Stairway; his cane by his side & holding the door knob." Although the report identified R45 was interviewable, the report did not indicate what R45 was attempting to do prior to the incident. R45 did not fall, sustained no injury and the interventions implemented to prevent further incidents were, "30 mins [minutes] checks, Wanderguard called MD [physician] to update." The report indicated R45's family was called at the time of the incident and the nurse practitioner (NP) was notified by telephone on 1/9/13 (three days later). Although R45 did not leave the facility, the 24-Hour Follow Up dated 1/9/13, indicated "30 min checks" were implemented and a Wanderguard was placed on	F 323	reviewed every day with stand up and all incidents are immediately reported to the DON. c. All residents are to be kept safe in their environment. If any resident has outburst that potentially could cause harm to others is immediately sent via 911 out of building. 3. Completion date: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x4 then monthly x3 with findings being presented to the QA committee for follow up discussion/planning. 5. Completion will be monitored by: Director of Nursing or Designee	

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F 323	Continued From page 183 R45. The RIR was signed by the administrator on 1/9/13 (three days after the incident). A corresponding Nurse's Note recapitulated the incident, indicated R45 had removed the stop sign and opened the doors. The note further indicated, "He was told not to go near the door as he may fall down the steps." The clinical record lacked evidence 30 minute checks were completed. - On 2/16/13, at 7:00 p.m. a Nurse's Note indicated R45 was confused, was up in his W/C and "Wanderguard intact." - On 7/1/13, at 5:30 p.m. an RIR indicated, "Resident [R45] wheeled himself outside the building," indicated the elopement was witnessed by the receptionist, and R45 stated, "I want to go outside and see the world." The report indicated, "NP paged to revisit for Wanderguard. Order received to place Wanderguard." The 24-Hour Follow Up section of the form dated 7/2/13, indicated, "Wandered outside, new Wanderguard placed, new 30 min checks implemented." The report was signed by the administrator on 7/3/13 (three days later). The section of the form which indicated a "VA [vulnerable adult, investigation]" had "N/A [not applicable]" selected. A corresponding Nurse's Note (same date and time) indicated staff was alerted R45 "was outside the building," the NP was contacted and a voicemail was left to obtain an order for a Wanderguard. Although R45 had a Wanderguard applied on 1/6/13, another Wanderguard was placed on R45. The clinical record lacked evidence 30 minute checks were completed. - On 7/2/13, at 3:00 p.m. an RIR indicated, "Resident [R45] went outside building without alerting staff." The report indicated R45 stated, "I went outside for freshair [sic], I will tell you next time." The report indicated the elopement was	F 323		

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F 323	Continued From page 184 unwitnessed. "New Wanderguard placed. 30 min v 's [checks] for PM shift then 1 hr [hour] checks." The 24-Hour Follow Up dated 7/3/13, indicated, "No further wandering." The new Wanderguard was documented as "placed on w/c d/t [due to] resident refusal to place on body stated only on w/c would be allowed." The report was signed by the administrator on 7/3/13, and the report indicated the incident was not reported to State agency (SA). The clinical record did not reflect documentation of the incident. A Nurse's Note dated 7/3/13, at 10:00 p.m. indicated R45 was on every one hour checks. Although documentation indicated R45 had a Wanderguard applied on 1/9/13, the Wanderguard was "intact" on 2/16/13, and a new Wanderguard was applied on 7/1/13, the 7/2/13 incident report indicated another Wanderguard was applied to R45's W/C. Although a Nurse's Note indicated R45 was on "1 hour" checks, the clinical record lacked evidence R45 was on 30 minute or one hour checks. - On 7/9/13, at 4:00 p.m. a Nurse's Note indicated R45 was attempting to leave the facility and the Wanderguard alerted the receptionist "who requested nursing staff assistance." The note indicated R45 was verbally aggressive, yelling at staff and attempts to redirect R45 were "ineffective." The note indicated R45 continued to yell until staff accompanied him outside the building. A therapeutic recreation staff person was assigned to walk with R45 outside. The note indicated, "Will continue 1 hr checks." - On 7/11/13 (no time written), a Nurse's Note indicated, "Res left building setting off alarm." The note indicated the receptionist attempted to redirect R45 verbally, but was ineffective. A nursing staff "ran out and caught him going fast down driveway ramp." The note identified R45 was verbally argumentative but came in with the	F 323		

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F 323	Continued From page 185 nurse. The clinical record lacked an RIR for the incident. Although the elopement was identified in the Nurse's Notes, the clinical record lacked evidence the elopement was reported immediately to the administrator, lacked evidence interventions were put in place to prevent potential future elopements and lacked a root cause analysis of the incident, such as how R45 was able to leave the building and the Wanderguard system alarmed. - On 7/11/13, at 4:00 p.m. another Nursing Note indicated R45 was "attempting to leave facility" and the Wanderguard alerted the receptionist "who called nurse station." The note indicated staff assisted R45 outside for "fresh air & exercise." The note indicated staff discussed with R45 scheduling walks and the need for staff accompanying R45 outside. The note further indicated, "Noted several unsafe factors including resident speed & inability to avoid uneven area, environmentally the sidewalk very uneven [with] several cracks & one incline that required intervention from writer to assist resident." The note indicated R45 "talked to all people that passed" and further described R45 "singing to people & unable to understand non-verbal ques [sic] from strangers. Judement [sic] in surrounding is poor." - On 7/18/13 (no time), a Nurse's Note indicated, "Alerted to resident leaving facility by Wanderguard." The note indicated R45 required several staff to assist with half a block of W/C mobility due to increased fatigue. - On 7/24/13, at 7:30 p.m. a Nurse's Note indicated a "New Wanderguard" was placed underneath and on the right side of R45's W/C. The note did not indicate why a new Wanderguard was placed on the W/C. - On 7/29/13, 4:00 p.m. an RIR indicated,	F 323		

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F 323	Continued From page 186 "Resident [R45] went outside the building unsupervised reported by the receptionist." The report indicated R45 stated, "I didn't go to the road but I was at the side walk they lied on me." The interventions section of the report indicated, "On hour Check." The 24-Hour Follow Up section dated 7/30/13, indicated, "Wanderguard is working no problem with behavior tonite N.P. here see New Orders." The report was signed by the administrator on 7/31/13, and indicated the incident was not reported to the SA. A corresponding Nurse's Note written at 9:35 p.m. indicated a voicemail was left for the nurse practitioner regarding R45 leaving the building unsupervised. The note indicated R45 denied leaving the facility and "became upset." The note indicated, "New Wanderguard put on his Lt [left] ankle." Although a Wanderguard was placed on R45's chair on 7/24/13, the clinical record lacked evidence why the Wanderguard was placed on the W/C versus on R45's ankle. - On 7/30/13, at 4:00 p.m. a Nurse's Note indicated R45 was "more agitated lately & wanting to leave the bldg. [building] & go around by himself." The note indicated R45 was "very resistant to redirection," the NP was present and Depakote (a medication used to stabilize mood) was prescribed for R45. Although the clinical record indicated Depakote was prescribed for the diagnosis of anxiety, the clinical record lacked evidence R45 was assessed for the use of the Depakote and lacked documentation for the clinical indications for the use of the medication. - On 7/31/13, at 9:00 a.m. an RIR indicated, "Resident [R45] went outside the building got stuck on the driveway blocked the incoming cars from entering. Witnessed by staff [licensed practical nurse (LPN)-H] & [trained medication aide (TMA)-F]. Resident statement indicated	F 323		

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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 323	Continued From page 187 "Yelling, uncooperative." The RIR indicated R45 exited the facility at the "back door." The interventions section indicated, "Replace Wanderguard, Depakote increased yesterday by NP f/u [follow up] w/ walking times w/ resident." The 24-Hour Follow Up dated 8/1/13, indicated, "Resident has responded well to program." The report was signed by the administrator on 8/1/13, and indicated, "Will be working w/OT [with/occupational therapy], staff to take out @ [at] 10 AM & 2:30 [p.m.] as desires. NP to re-evaluate medication." The report indicated the incident was not reported to the State agency. A corresponding Nurse's Note written at 9:19 a.m. indicated the NP was called regarding R45 leaving the building, identified R45 as "unsafe propelling self-blocking traffic." The note indicated R45 was yelling and "doesn't respond to redirection." A note written at 4:10 p.m. indicated R45 had an OT order for "community safety when outside." Although the notes indicated R45 was not easily redirected, the clinical record lacked evidence the Wanderguard system was evaluated for function, such as how R45 was able to leave the building or if the Wanderguard system malfunctioned. The clinical record lacked evidence the Wanderguard checks for function and placement by the nursing staff were effective. Throughout the survey on 8/12/13, through 8/14/13, R45 was observed to move about the first and ground floor levels of the facility independently with use of the elevator. R45 was observed to go to the ground floor dining room independently for meals. A Wanderguard was observed to be affixed to the metal W/C frame under the seat. The front entrance of the facility was observed to have set of accordion doors directly in front of the reception desk. These	F 323		

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 323	Continued From page 188 doors opened to a breezeway leading to two doors opposite each other. The door to the right lead to the street side of the building which had a sloping driveway ramp leading to the street. The door to the left lead to the back of the facility and the facility parking lot approximately 30 to 35 feet from the building. All three doors were observed to have a Wanderguard device next to the door frames. The Resident Admission Record indicated R45 was admitted to the facility on 9/19/12, with diagnoses to include vascular dementia, dysphagia, muscle spasms, osteoporosis, persistent mental disorder, depressive disorder, hypertension, and left hemiplegia. The annual Minimum Data Set (MDS) dated 9/25/12, indicated R45's BIMS (a Brief Interview of Mental Status, a tool used to measure cognition) score could not be completed and identified R45 had short and long-term memory impairments; R45 required limited assistance with walking and transferring; required supervision with locomotion on the unit and required extensive assistance with locomotion off the unit. The MDS indicated a cane and/or a W/C were his mobility devices. The Cognitive Loss/Dementia-CAA (Care Area Assessment) dated 9/25/12, identified R45's cognitive losses and R45 was not independent with decision making skills, was inattentive, had disorganized thinking, had physical behaviors towards others and rejected cares. The CAA identified R45 had "a difficult time adjusting to the move" and identified specific physical behaviors, suicidal risk and referral to the psychiatrist. The Activity of Daily Living (ADLs) Functional Status/Urinary Incontinence/Pressure Ulcers CAA identified R45 was able to ambulate short	F 323		

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F 323	Continued From page 189 distances with staff assistance and a quad cane, but the W/C was R45's primary source of locomotion. The CAA for Falls/Psychotropic Medication Use dated 10/2/12, indicated R45 had balance problems, was not steady, but was able to stabilize without staff assistance. The CAA indicated R45 "could be impulsive at times." The quarterly MDS dated 6/21/13, indicated R45 had a BIMS score of 10 (moderate cognitive impairment); he required extensive assistance with ADLs of transferring, locomotion on and off the unit, dressing, grooming, and toilet use; he required limited assistance with walking in and out of the room. The Risk of Elopement/Wandering Review indicated R45's potential risk factors for elopement were reviewed. The reviews indicated the following: - On 9/20/12, the review identified R45 "tries to go out stairway exits which have stop signs." The review indicated R45 "has Wanderguard on" and a tabs alarm on at all times. The review indicated R45 had personal safety devices applied, had "frequent monitoring" but did not identify the frequency of the monitoring and "Wanderguard." - On 12/19/12, and 6/15/13, the reviews identified R45 was not at risk for elopement or wandering. - On 7/2/13, the review indicated, "Leaving into facility parking lot without notifying staff. States, 'I want to exercise.' Cognitive/physical issues unsafe without supervision." The additional comments section of the review indicated, "Wanderguard placed." Although the reviews indicated a Wanderguard was applied to R45 after the 9/20/12 review, the clinical record indicated a Wanderguard was "applied" to R45 again on 1/9/13. A note on	F 323		

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F 323	Continued From page 190 2/16/13, indicated the Wanderguard remained on. The clinical record lacked evidence if and when the Wanderguard was removed. Although a Wanderguard was documented as "applied" on 7/2/13, the clinical record did not identify if a Wanderguard was applied on 7/1/13, or after the 7/2/13, elopements from the facility. The clinical record lacked evidence R45's elopements on 7/11/13, 7/29/13 and 7/31/13, were reviewed. R45's care plan dated 9/27/12, identified, "Resident at risk for harm from self or others R/T [related to]: 1. Dx [diagnosis] of depression 2. Dx of CVA [cerebral vascular accident, stroke] 3. Dx of persistent mental disorder... AEB [as evidenced by]: 1. Resdient [sic] has a history of making suicidal statements/actions." The care plan dated 10/9/12, identified R45 had, "Impaired Communication r/t impaired cognition, dementia - persistent mental d/o [disorder]...ability to make self understood & understand others is impaired." A hand written care plan for falls dated 10/21/12, identified R45 had potential for fall r/t weakness and left hemiplegia (paralysis on the left side). The care plan dated 7/31/13, indicated, "Resident prefers activities that identify with prior lifestyle i.e. [in example] walking program" and identified R45 would "have staff walk him at 10 AM and 2:30 PM. If he is compliant with sticking to these times resdient [sic] will get a treat of his choosing. Resdient [sic] to sign a walking program contract agreeing to above." The interventions further directed, "OT to work with resdient [sic] (modified community integration with behavior mod [modification])." A hand written update dated 7/13 indicated, "1 Wanderguard applied [crossed out] initiated - check placement/function per protocol. 2 Post photograph of resident at appropriate place 3 Allow safe mobility in uncluttered	F 323		

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F 323	Continued From page 191 environment 4 Encourage movement & exercise in environment 5 Redirect & reorient in gentle manner 6 Offer calm reassurance, 7 Reapproach if resistive 8 Cont [continue] walks outside w/ staff 1-2 x day weather permitting." In addition, the care plan identified R45 could be physically and verbally abusive; he resisted care, made negative statements, and he had a history of "attempting to choke self with hand." Although the care plan identified R45 had a Wanderguard. The care plan did not identify R45's elopement risk, elopements from the facility or attempts to enter unsafe areas of the facility, such as the stairwell. The care plan lacked interventions to address prevention of elopement, such as placement of the Wanderguard, R45's history of attempts to remove the Wanderguard, reasons for the Wanderguard, nursing interventions to address elopement attempts. Although the care plan identified a "walking program" for R45, the care plan did not identify if R45 was supposed to walk with a cane or to be escorted while R45 used a W/C. The care plan lacked safety consideration related to elopements, such as safety assessment schedules or R45 refusing to allow the W/C to be touched while out on the walking program. The undated Nursing Assistant (NA) Assignment Sheets AM/PM for R45's team directed, "Wanderguard-underside of w/c" and directed, "Mobility program with resident- CNA [nursing assistant] to assist outside of facility." The sheet directed to set aside "30 min" for the activity. On 8/14/13, at 2:29 p.m. R45 was observed for his scheduled 2:30 p.m. walk. At that time, a NA-K was observed to escort R45 down the back	F 323		

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F 323	Continued From page 192 key locked service elevator (due to a service delay with the main elevator). A door leading to the parking lot on the back of the facility was observed to have a "Wanderguard, Inc." device plugged into the wall to the left of the door. R45 quickly wheeled out of the elevator and towards the door independently. NA-K quickly moved in front of R45 and quickly opened the door. NA-K held the door and R45 wheeled out quickly into parking lot. At no time during the observation did the Wanderguard device alarm or lock the back door to the facility. The parking lot was observed to be at a decline toward the street, the surface of the parking lot was uneven. R45's W/C was observed to roll, picking up speed, down the decline across the parking lot and towards the street. R45 did not make an effort to slow the momentum and roll of the W/C. NA-K verbally cued R45 to "wait for her," but R45 did not comply and made no indication he had heard NA-K. NA-K was observed to run to catch up with R45 just before he reached the end of the parking lot and side walk. NA-K then escorted (without touching the W/C) R45 to the left down the sidewalk and off the facility property. - At 2:37 p.m. receptionists (R)-J and R-K were both interviewed. R-K stated she worked the day shift and both confirmed R-J worked the evening shift. Both stated R45 had "gotten out [eloped] once" per their recollection. R-K stated R45 last eloped from the facility "months ago" and stated, "It was my fault; I didn't know [R45] wasn't supposed to leave." R-K pointed to the front door and stated R45 had "made it out" of the facility and was "in the parking lot." R-K stated she called other facility staff for assistance. Both receptionists stated R45 had a Wanderguard, but believed it was applied, "Months ago." They stated they knew who was allowed to go outside	F 323		

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F 323	Continued From page 193 alone and who was not. Both stated they were informed verbally and in writing of any changes in resident status, or if new residents were admitted. Both receptionists explained the Wanderguard system "locked the door" and in order for R45 to leave the building, they had him remain back from the door and then opened the door for him manually. The receptionist explained if "staff went before" R45 and opened the door, R45 would be able to leave the facility. When asked during the interview, the receptionists were unclear if the Wanderguard system alarmed. When asked regarding the procedure for if a resident attempted to leave the facility (elope), both receptionists stated the procedure was to call for assistance. R-K verified she did not attempt to stop R45 from leaving the facility. - At 2:39 p.m. the admissions coordinator (AC) entered the conversation with R-J/R-K and stated there was a binder with pictures of all residents (including R45), kept at the receptionist desk. AC stated the receptionist were aware which residents could and could not leave the facility. AC further stated all residents' picture and descriptive information were in the binder at the receptionist desk so resident information could quickly be provided to the Police as needed. AC stated if there were changes to a resident's status for leaving the facility, the receptionist staff were updated verbally and in writing. - At 2:45 p.m. the registered nurse (RN)-B verified she usually worked on R45's unit. When asked who was responsible for checking the placement and function of R45's Wanderguard, RN-B stated, "I don't know, Q [every] shift ...the aides [nursing assistants, NA's] can do it too." RN-B stated she was sometimes "busy" and had the NA staff check the Wanderguard. When asked how the Wanderguard system was	F 323		

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F 323	Continued From page 194 checked for function, RN-B stated "they" carried a "little box" to the Wanderguard and checked it to see if it was working, "If it [the box] lights up, its working." RN-B stated the box was in a drawer at the nursing station. RN-B opened a cabinet and looked for the box. RN-B stated, "Of course, it's not here." RN-B checked several drawers at the nursing station, but the box for checking the Wanderguard was not located. RN-B was unclear when the Wanderguard was last checked for function. - At 2:49 p.m. R45 returned to the unit with NA-K. NA-K thanked R45, R45 then wheeled into his room. NA-K stated R45 was returned to the facility through the front door and confirmed the alarm did not sound when R45 entered the facility. NA-K did not recall if the facility door locked and stated she went before R45 and the door opened. NA-K verified the back door did not alarm when she and R45 left the facility and verified the door did not lock. NA-K verified she opened the door first, but was unclear if the door should have locked or alarmed. NA-K verified she was usually assigned to R45. - At 5:10 p.m. the LPN-F confirmed she worked on R45's unit the previous day (8/13/13). When asked why R45 had a Wanderguard, LPN-F stated R45 was at risk for injury and had "bad safety judgment." LPN-F stated R45 would not remain on the property and would "attempt to leave the property." LPN-F further explained R45 gets "fanciful ideas" which were not easy to predict. LPN-F stated R45 "got stuck in the parking lot ...a couple weeks ago" and explained being in the parking lot was unsafe for R45. When asked about where R45's Wanderguard was located, LPN-F stated she "wasn't sure." LPN-F was unclear about when and how the Wanderguard was checked for function.	F 323		

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F 323	Continued From page 195 R45's signed Patient Medical Care Plan (Physician's Orders) dated 11/15/12, through 7/31/13, all directed, "Wanderguard check placement & function every shift." A Telephone order dated 7/2/13, at 8:00 a.m. indicated, "OK for Wanderguard." The Integrated Care by Medica form dated 7/12/13, at 2:25 p.m. indicated R45 was seen by a NP. The form identified, "Multi-infarct dementia: increased wanting to go out for 'exercise'. Over the last 3 days has attempted to leave the building independently so staff has now needed to place a wander guard on his w/chair. Pt [patient] states the weather is nice and the porch is not an option as people 'smoke out there.'" The A/P [assessment/plan] section indicated R45 had, "Vascular Dementia uncomplicated: status; chronic dementia with behaviors and depression. Pt has little tolerance for waiting for anything. He has low frustration tolerance by hx [history] and redirection often does not work." Review of the Medication Administration Records (MARs) and Treatment Administration Records (TARs) from March 2013 to August 2013 indicated the following: - The months of March and April 2013 indicated the Wanderguard was assigned to be checked for placement and function every shift and signed off by the licensed nursing staff. - The months of May and June 2013 did not include documentation of Wanderguard placement or function. - The month of July 2013 indicated Wanderguard placement checks were done every shift and function checks were completed every morning and identified the Wanderguard was applied on	F 323		

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F 323	Continued From page 196 R45's left hand. On 7/24/13, a new Wanderguard was applied to the W/C. - The MAR/TAR for August 2013 lacked documentation of Wanderguard placement and function checks. The MAR/TAR indicated R45's Wanderguard was not checked for placement or function until the evening shift of 8/14/13, and the checks were added after the surveyor questioned the documentation. The MAR/TAR indicated function checks were scheduled to begin on 8/14/13, on the NOC shift. On 8/14/13, at 7:00 p.m. the administrator met the surveyors at the front entrance of the facility. The administrator had a Wanderguard in his hand and stated he was concerned the surveyors had reported the Wanderguard "didn't alarm." The administrator carried the Wanderguard to the front entrance and demonstrated the automatic accordion doors locked. The administrator walked away from the door and the door was able to be opened after an approximate 15 second delay. The administrator attempted to walk through the front door and an alarm sounded. The administrator was unclear if the other entrances of the facility would alarm when R45 attempted to exit. The administrator verified the Wanderguard transponder was a new device and not the same device as R45. The administrator was unclear if R45's Wanderguard was functional and would have caused the door to alarm. On 8/15/13, at 9:53 a.m. NA-H stated the nursing assistant staff checked the Wanderguard placement in the morning. NA-H stated she attempted to do this before R45 was in the W/C and showed the Wanderguard transmitter was out of R45's reach. The Wanderguard was observed to be affixed with a short strap, under	F 323		

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F 323	Continued From page 197 the seat and strapped to the metal frame of the W/C. NA-H stated she checked the transmitter to make sure it was there and stated R45 would "try to take it off." NA-H stated the Wanderguard "could be checked" by taking the W/C to the door and see if it was functional, but was unclear when this had been done last. NA-H was unclear if there was a device used to check the function of the transmitter. NA-H stated the Wanderguard transmitters were only good for "30 days." The Wanderguard under R45's W/C was undated. On 8/15/13, at 1:41 p.m. the RN-A confirmed she had worked in the facility at the time of the elopements. RN-A stated she believed the Wanderguard was applied to R45 on 7/2/13. RN-A stated R45 was placed on "checks" 7/1/13, the order for the Wanderguard was obtained at 8:00 a.m. on 7/2/13, but was unclear when the Wanderguard was applied. RN-A verified R45 eloped from the facility at 5:30 p.m. on 7/2/13. RN-A verified Wanderguard policy was to "check function daily and placement every shift." RN-A described checking function was completed by using a "box thing" which had lights to indicate if the Wanderguard was functional. RN-A also stated staff could bring R45 near the door to check for function of the Wanderguard. RN-A explained R45 had been found to have the Wanderguard missing, but was unclear when. RN-A verified the clinical record did not include documentation of the Wanderguard placement and function checks. RN-A stated the Wanderguard was moved from the wrist to under the W/C seat on 7/24/13, after the Wanderguard was found to have been removed by R45. On 7/2/13, RN-A stated the Wanderguard did not go off and explained the system had a "15 second laps." RN-A stated staff were usually alerted via	F 323		

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F 323	Continued From page 198	F 323		

the Wanderguard. RN-A stated R45 had reached the outside of the main door by the time staff had arrived. RN-A stated it was the same for the 7/29/13 elopement. RN-A stated although the RIR indicated R45 left via a "back door," RN-A stated R45 actually left the facility via the main (accordion) doors, but left the breezeway and building via the door leading to the back of the building and parking lot. RN-A stated she was unaware of R45 exiting the facility via any other door, but was unclear if the alarm continued to sound or turn off after a period of time.

On 8/15/13, at 3:35 p.m. the RN consultant stated the "back door" R45 eloped from on 7/31/13, was not the door the surveyor observed on 8/14/13. The consultant stated she was present at the time of the elopement. The consultant and surveyor observed the front door entrance and the two opposite door entrances in the breezeway before the accordion doorway entrance to the facility. The consultant stated (when facing away from the receptionist desk towards the accordion doors) the breezeway door to the right was the "front door" which lead to the street and the door to the left was the "back door" which lead to a parking lot. Wanderguard devices were observed on both doors. The consultant brought the surveyor to the end of the sidewalk and to the parking lot and stated, "This is where we found [R45] (approximately 35-40 feet from the doorway)" and pointed to the pavement off of a ramp in the parking lot. The pavement of the parking lot area was observed to be uneven, with many grooves and pot holes. The area the consultant indicated R45 was found blocking traffic on 7/31/13, was the turnaround area for parking lot traffic, leading to a street. The consultant stated to access the doorway the

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F 323	Continued From page 199 surveyor observed on 8/14/13, was only accessible by elevator (with a key) and the door leading to the back aspect of the facility had a Wanderguard device connected to it. The consultant RN and surveyor observed the door R45 exited the building at on 8/14/13. The door entering the activity area (and leading to another back exit) was observed to have a Wanderguard attached to the left side of the door. The environmental director was observed to be checking the wiring of the Wanderguard to the door in the activity area. The environmental director stated the Wanderguard at the back aspect of the nursing home (used as an exit for a walk with staff by R45 on 8/14/13) should have "alarmed," but the door should not have locked. He stated the Wanderguard on the "front" and "back" did not lock the door but should "alarm." The environmental services director stated the "15 sec" delay was for the magnetic lock on the Wanderguard system on the second floor and did not apply to the front of the facility exits. The environmental director stated staff should be aware of the different aspects of the Wanderguard system including the location of the alarm sounds. The environmental director re-stated the Wanderguard on the door observed on 8/14/13, "Should have alarmed. " On 8/16/13, at approximately 8:00 a.m. the administrator confirmed the facility did not have the testers to check if the Wanderguard bracelets were functional. The administrator stated the testers were ordered and would be "arriving today." The administrator confirmed the facility's procedure was to have the Wanderguard checked for function every shift. The administrator stated the Wanderguard devices on the two doors in the breezeway were removed	F 323		

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and the main accordion door to the breezeway directly in front of the reception desk was the last point of entry/exit for the Wanderguard system. The administrator was unclear how staff was checking R45's Wanderguard for function without the tester.

On 8/16/13, at 9:30 a.m. the social service designee (SSD)-A stated she was involved with the elopements when they were brought up in the IDT [interdisciplinary team] meetings. SSD-A stated every time R45 had been out of the building, the receptionist called and R45 was able to be brought back in the building. SSD-A confirmed R45 had "gotten out [eloped]." SSD-A stated the majority of the behavior problem was R45 wanted to go "now," and described a situation, such as in the middle of when staff was assisting other residents with eating. SSD-A stated the interim DON (the consultant RN) "sat down and created a walking program" with R45. SSD-A stated R45 chose the times he was willing to go out and be escorted out of the building. SSD-A further stated, "My involvement has been limited." SSD-A verified she completed the mood and behavior sections of the care plan and confirmed the care plan did not address R45's elopements from the facility.

On 8/16/13, at 11:46 a.m. the administrator was interviewed regarding R45's elopements from the facility. The administrator stated he was usually notified via telephone regarding "reportable events" and stated he did not keep a log of when he was notified. The administrator stated he did not consider the times R45 left the facility as "reportable" or "elopements" because the receptionist called and notified staff R45 was going out the door and "staff were on their way to

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help." The administrator added he viewed the incidents when R45 left the facility on 7/1/13, 7/2/13, 7/11/13, 7/29/13 and 7/31/13 as not elopements because R45 was being "observed" while he left the building and was "safe." When asked if R45 was being escorted by staff out of the building, the administrator stated staff was not physically with R45 in those times. The administrator further stated he was not sure if R45 "actually went out of the building." The administrator expressed he disagreed with what was considered an elopement and confirmed he was not notified of the incidents because the elopement was not reportable. The administrator stated his signature and date on the incident reports were when he had "reviewed the incident reports" and "don't indicate when he was informed of the incident."

On 8/16/13, at approximately 12:50 p.m. a surveyor observed NA-H and NA-A come and speak to LPN-C. LPN-C was observed to be watching a car accident which had just occurred on the corner of 29th Ave N and Emerson Street from the West window on 2nd floor. Both NA staff simultaneously stated to LPN-C, "This is why we always tell you guys that [R45] should not be going outside. We've seen him go down that way. He's going to be hit by a car very soon." LPN-C did not respond.

On 8/16/13, at 1:45 p.m. the DON was interviewed regarding elopements, and stated she believed an elopement was reportable to the SA when a resident left the "facility property." The DON stated that was why the elopements were not reported to the SA. The DON stated she believed since the receptionist saw R45 leave the facility, had called for assistance and R45 was in

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F 323	Continued From page 202 visual sight, it was not considered an elopement. The DON confirmed the elopements occurred prior to her employment to the facility; verified the sidewalk around the facility, the parking lot and pavement was uneven and unsafe. The DON verified she had walked with R45 outside the facility and R45 would not always allow her or staff to touch the W/C. The DON verified R45 was able to move fast when wheeling the W/C outside the facility. On 8/16/13, at 3:58 p.m. RN-A stated checking for Wanderguard placement and function could be "delegated" to NA staff, but the nurse documented the results. RN-A stated she remained unclear if or when the Wanderguard was removed in July, but stated she thought the Wanderguard was first applied to R45 on 11/2012. On 8/19/13, at 10:05 a.m. the occupational therapist verified R45 was in therapy for "community involvement." Occupational therapist stated the treatment was to develop approaches with R45 while he was out on walks in the community. Occupational therapist stated R45 did not want staff to be with him and the nursing staff was "confused" on behavioral approaches with R45. The occupational therapist stated therapy staff provided teaching on how to talk to R45. The occupational therapist stated she went out with R45 on the walks, timed them and explained to R45 why staff was with him; encouraged R45 to choose times and for staff to not make R45 feel "isolated" as he was being escorted on these walks. The occupational therapist denied the therapy was to "prevent" potential elopements and stated the therapy was to assist with compliance with the walks around the block twice	F 323		

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F 323	Continued From page 203 daily. The Elopement Assessment policy and procedure dated as revised on 5/15/13, identified the facility policy was to assess each resident to identify potential risk factors for elopement. The policy identified, "All residents will be assessed on admission and annually for elopement. That resident determined to be 'at risk' for elopement will be assessed quarterly." The policy directed the completion of the "Elopement Risk Assessment [Risk of Elopement/Wandering Review]." The policy further directed to apply appropriate interventions from the "list" at the bottom of the form, directed to complete an "elopement prevention/management care plan." The policy further directed, "8. If Wanderguard is an intervention. Test Wanderguard to ensure it [sic] working properly before putting on resident. 9. Implement signaling device testing calendar, test Wanderguard daily and sign daily that it is tested and working." The undated Wanderguard Departure Alert System manual directed to use a "Universal tester" within one foot of the Wanderguard bracelet, press and release the bracelet button one time, the tester light will blink green four times if the bracelet was active and has tested as "good." The manual also included directions to test the Wanderguard at the door to determine function. The manual further directed to keep the Wanderguard away from metal jewelry if applied on a resident, or away from metal when affixing it to a W/C. The manual directed to mount the Wanderguard on the back of the W/C and not against the metal frame and indicated the metal may "interfere" with the Wanderguard function. R45's Wanderguard was placed at the metal	F 323		

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F 323	Continued From page 204 crossbars of the W/C. The immediate jeopardy that began on 7/1/13, was removed on 8/16/13, when the facility corrected the deficient practice as the facility had replaced R45's Wanderguard, tested all Wanderguard systems currently used on other residents for function, three new Wanderguard testers were ordered and obtained, the Wanderguard protection at the front entrance was evaluated and changed, and staff training was provided on these changes. The facility established a monitoring system which included audits and revised the Wanderguard policy for ongoing compliance. R87's admission MDS dated 12/11/12, indicated R87 had no fall history. R87 was able to ambulate in the room independently, however, R87 needed supervision on off the unit. The Falls CAA dated 12/18/13, indicated R87 had fall risk factors present. R87's falls were not comprehensively assessed as R87 continued to fall and the plan of care was not implemented and/or revised with interventions to minimize potential injuries from the falls. The lack of evidence in the medical record to minimize the injury due to falls placed R87 at harm. The CAA Falls lacked any comprehensive assessments of the risk for falls or as possible contributing factors. The risk of injury from falls care plan dated 12/24/12, indicated see the ADL, psychotropic medication, mobility may vary d/t cognitive impairment and balance, and incontinence care plans. Additional interventions included assist of one to sit up in bed, update MD/NP as needed, interdisciplinary team (IDT) review as needed, redirect when unsafe with ambulation, lay down for nap after lunch, and provide five minutes	F 323		

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F 323	Continued From page 205 sensory stimulation and Wanderguard. During observation on 8/12/13, at 5:42 p.m. R87 was noted to have dark purple bruising on the knuckles of the left hand and dark purple bruising to the right wrist area. When asked, R87 reported she fell down the stairs. During observation on 8/15/13, at 9:16 a.m. R87 continued to have the bruising to the left knuckles and the right wrist and another 7 centimeter (cm) x 4 cm dark purple was noted to R87's left forearm. During observation on 8/16/13, at 8:00 a.m. R87 was observed walking from her room to the dining room with only white stockings on her feet. NA-I assisted R87 to sit in a dining room chair and did not provide foot wear. At 10:23 a.m. NA-I put shoes on R87's feet. During observation on 8/14/13, at 3:07 p.m. R87 was noted to wander on the unit entering and exiting rooms. When R87 observed R82 sitting in room 214 (a third resident), R87 entered 214 and stayed with R82. The Resident Incident Reports reviewed from 1/13 through 8/13, for R87 revealed: On 1/1/13, at 3:00 a.m. R87 was found sitting on the floor in room 209 and was escorted back to her room. The RN assessment indicated may need 1:1 care when up and trying to go into other resident rooms. There was no evidence 1:1 care was provided or that any other interventions were identified. On 1/3/13, at 3:30 p.m. R87 was noted to have gotten up from a chair in the dining room, lost	F 323		

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F 323	Continued From page 206 balance and fell. Intervention noted was elbow protectors applied. Ongoing intervention was to monitor hourly and ensure elbow protectors were in place. The plan of care lacked the interventions of the elbow protectors and the hourly checks. On 1/20/13, at 7:00 a.m. R87 was noted to have fallen over a blanket from another resident's bed. No interventions were identified. On 2/1/13, at 8:10 a.m. R87 was observed sitting on the floor with blood covering her forehead, with an abrasion to her forehead. Intervention noted was to redirect when possible, with ongoing intervention noted as difficult to redirect at times. The RN assessment included, R87 would be monitored hourly. R87 would not sit still and was resistive to attempts to separate her from another resident. The plan of care lacked the hourly interventions that were already in place with the 1/3/13 fall. The care plan still lacked the elbow protectors. On 5/4/13, 9:30 p.m. R87 was noted to have lost her balance and fallen to the floor after another resident took a door handle from her. R87 was noted to have a bruise to the hip, no size was identified. No immediate interventions were identified and the RN assessment indicated to continue to monitor R87's whereabouts. On 5/6/13, 8:30 a.m. R87 was found sitting on the floor in her room. The immediate intervention was 30 minute checks. The ongoing intervention was to continue 30 minute checks, notify MD for medication review, sleep study and encourage frequent rest periods. The MD ordered Risperdal (an antipsychotic medication). The medical record lacked any form of an falls and psychoactive medication assessment for the Risperdal use. On 5/7/13, 10:10 a.m. R87 was found sitting on the floor. The immediate intervention was to	F 323		

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F 323	Continued From page 207 request a physical therapy order and to continue to monitor R87 every half hour. No physical therapy notes were discovered. On 5/8/13, 10:05 a.m. R87 was found sitting in the hallway and was noted to have reddish, brown and purple bruise on the outer left leg and buttock (no size noted). Immediate interventions noted as placed call light near resident and monitor R87's whereabouts. The RN assessment included to be monitored every 15 minutes, elbow pad, hipsters and rule out a urinary tract infection. A physician's order dated 5/9/13, directed to x-ray the left femur and hip, okay for hip and elbow pads. The elbow pads and the hipsters were not available for staff to place on R87. On 5/27/13, 8:30 a.m. R87 was found sitting on buttocks in the doorway with a 2 cm laceration to the right elbow. The RN assessment was to not tuck R87's covers in when in bed. No immediate interventions were noted and the 24 hour follow-up indicated to monitor every 15 minutes (an intervention already implemented). On 7/3/13, 1:45 p.m. R87 was found sitting on the floor with her back to a chair. The immediate intervention was to monitor R87 closely. The RN assessment included to intervene when R87 was noted performing unsafe tasks, bring for a nap after lunch and provide five minute stimulation to encourage rest. The medical lacked evidence the interventions were being monitored. On 7/11/13, 10:00 a.m. R87 was found sitting on the floor in the dining room. The immediate intervention included to take R87 to an activity of the floor for 30 minutes. The RN assessment indicated to assist to daily activities and encourage her to lie down after breakfast and lunch to prevent fatigue. The medical record lacked any comprehensive assessments of the repeated falls.	F 323		

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F 323	Continued From page 208 A Nurse's Notes dated 4/28/13, indicated R87 was seen lowering herself to the floor and was found to have a skin tear on the left hand. On 4/29/13, a Nurse's Notes indicated R87 had more bruises noted to the body. No Resident Incident Reports were provided for 4/28/13 or 4/29/13. The Resident Incident Report included a place for orthostatic blood pressure; however of the twelve falls from 1/1/13 through 7/11/13, only two had orthostatic blood pressures recorded. When interviewed on 8/14/13, at 1:10 p.m. the director of nursing verified there also had been no monthly orthostatic blood pressure monitoring for R87 related to psychotropic medication use. Review of the May 2013 through August 2013 TARs showed the hip and elbow protectors were circled every day and noted as not available. A Physician's Telephone Orders dated 8/14/13, indicated "Ok to d/c [discontinue] hip protectors, elbow protectors and Ted hose [anti-embolism stockings] d/t non coverage." However, the order was not present in the medical record when the record was reviewed on 8/16/13. The medical record lacked evidence of the care plan being implemented and any falls interventions and/or alternate falls interventions being put into place to minimize potential injury from falls. When interviewed on 8/14/13, at 9:19 a.m. LPN-D stated bruises were monitored in the Nurse's Notes. During an interview on 8/16/13, at 11:11 a.m. the nurse consultant (O)-D stated bruises are tracked on incident reports. When asked about the	F 323		

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F 323	Continued From page 209 implementation of the interventions and the care planning process of the related falls with injuries O-D made no comment. On 8/19/13, at 2:09 p.m. the DON was again asked for documentation regarding assessment and intervention for R87's bruises noted throughout the survey. None was provided. The NP was interviewed on 8/19/13, at 11:10 a.m. regarding Risperidone (an antipsychotic) and Celexa (an anti-depressant) use for R87. The NP stated R87 had a long standing history of depression including tearfulness, anxiousness and knew she was not with her daughter. The NP noted with the trial off Risperidone, R87 had increased pacing, not sleeping and increased falls. The NP stated with the Risperidone restarted R87 had no tears and interacted better with her peers. The NP stated R87 had "paranoia" of going to bed and was afraid to be in bed and she wanted R87 to be comfortable not just sedated. When asked if she knew the as needed (PRN) Risperidone had not been used as ordered after the scheduled Risperidone had been discontinued, the NP stated the nurses were just trying to "tolerate" R87's behaviors. The NP stated R87 was a "big fall risk" and the NP had to "be careful what to use for her [R87]." A policy regarding ongoing monitoring of resident's skin condition was requested but no policy was provided. R87 remained at harm due to the lack of a comprehensive assessment for the falls and lack of implementation and /or revision of interventions to minimize the injury from potential falls.	F 323		

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F 323	Continued From page 210 R65's hospital note dated 1/21/13, indicated R65 was wandering around the halls and into patient rooms and was easily redirected. Resident admission Record dated 1/22/13, noted R65 to have diagnoses to include dementia, alcohol abuse, depressive disorder, Alzheimer's disease, osteoarthrosis and history of brain injury. R65 had a history of wandering into other resident rooms which place him and other resident(s) in harm's way for the potential of an altercation. The facility did not identify and/or implement interventions for R65 to decrease the behaviors. During observation on 8/12/13, at 6:15 p.m. R65 got up from the table and wandered away from the dining room. The nurse in the dining room stated R65 would come back shortly to finish eating. A beeping noise was heard from the north stairwell area, LPN-A stated "that's just [R65]; it will stop when he moves away from the door." All staff remained in the dining room area. R65 wandered back to the dining room, did not sit down and wandered away again. On 8/12/13, at 6:45 p.m. R65 was noted sitting in a chair in room 214. The resident from 214 was sitting on the bed when R65 was observed in the room. When the surveyor approached R65, he got up quickly with a fearful look on his face and left room 214. On 8/13/13, at 12:25 p.m. and again at 12:43 p.m. R65 was observed wandering in the hallway. On 8/13/13, at 2:07 p.m. R65 was observed wandering into room 224. A NA approached R65 and redirected him to his room. R65 refused to go into his room and the NA walked away. On 8/13/13, at 2:26 p.m. R65 wandered into room 224, two nurses and two NAs walked by R65 and did not redirect him from room 224. On 8/13/13, at 2:48 p.m. the admissions	F 323		

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coordinator was observed looking for R65. R65 was found in room 214 and was redirected out of the room.
On 8/13/13, at 3:13 p.m. R65 was observed wandering into room 223.
On 8/14/13, at 7:48 a.m. R65 was observed in bed in an empty room with staff providing one on one observation.
On 8/14/13, at 3:05 p.m. R65 was observed wandering into other resident rooms; staff was not observed to be monitoring R65's whereabouts.

An Assessment For Resident Vulnerability, Safety And Risk To Others assessment dated 1/22/13, indicated R65 "swears/yells, attempts to hit if he is mad and hits/strikes out" as a potential risk to others and was noted as "does not appear to pose a threat to other residents." No other Assessment For Resident Vulnerability, Safety And Risk To Others assessment had been completed once R65 started and continued with physical altercations.

The Cognitive Loss/Dementia CAA dated 1/29/13, identified R65 as having had episodes of both physical and verbal aggression, wandered on the unit which included into other resident rooms.

A care plan dated 1/29/13, indicated R65 was at risk for harm from self or others. A care plan dated 1/29/13, indicated R65 had physically and verbally abusive behavioral symptoms with no changes in interventions noted. The altered thought process care plan dated 2/11/13, indicated R65 wandered without purpose and directed to allow for safe wandering in an uncluttered environment and re-approach if resistive. Changes to interventions were noted on

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F 323	Continued From page 212 6/13/13 as thirty minute checks and on 7/13/13, to offer bed if wandering into rooms and place blanket over to encourage rest. The intervention of fifteen minute checks was added on 8/14/13 (during the survey) and was discontinued on 8/15/13, when one on one was initiated. Prior to the survey, R65 had not been on one to one observations. On 8/16/13, the intervention of fifteen minute checks was restarted with directions to complete for three days and then discontinue. The care plan lacked evidences what triggered R65's behavior and how to protect R65 from other resident's behaviors. Review of the Nurse's Notes from 1/23/13 to 2/10/13, indicated R65 was admitted on 1/22/13, and began to wander on the unit shortly after admission and was combative with cares. R65 was noted to have been pacing the hallways; entering other resident's rooms and lying down on their beds and floor mats. Also, the following was noted: - On 2/8/13, R65 was noted to be reaching for other resident's food and the other resident was upset and the residents had to be separated. - On 2/10/13, R65 was observed to have picked up food from another resident's tray, when staff intervened, R65 took water off the tray and threw it on the other resident and then attempted to strike staff. The intervention was to not place R65 at a table near other residents. (However, during the observations on all days of the survey R65 continued to walk across the dining room and go to other resident tables. No staff was observed to re-direct R65 at the times it had occurred.) There were no Nurse's Notes included from 2/4/13 until 4/24/13. R65 was again noted to have been pacing on the unit and going into other resident's rooms from 4/24/13 through 4/28/13.	F 323		

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F 323	Continued From page 213 - On 5/6/13, R65 was noted to have pushed another resident while attempting to eat off of the other resident's meal tray. The Nurse's Notes did not indicate what interventions or actions the facility staff had taken to minimize R65's behavior. - On 5/21/13, R65 was noted to have blood on the left hand and was reported to have opened an old bruise. - On 6/1/13, R65 was reported to have hit another resident in the face after being chased out of a third resident's room where R65 was hit on the left leg and hip with a "reacher stick" no injuries were noted. - On 6/7/13, R65 hit another resident on the right arm when the other resident asked him to get out of his bed. - On 6/24/13, R65 was found at the bottom of the back stairwell pacing in a circle, noted door did not alarm. - On 6/25/13, a new Wanderguard was placed on R65. - On 6/29/13, R65 was noted to have been in another resident's room and the other resident was noted to have a torn shirt and reported R65 attacked him. - On 6/27/13, R65 was again noted to be wandering into other resident rooms and lying in bed while remaining on every 30 minute checks. Throughout the month of July 2013, R65 was noted to be pacing and going into other resident rooms. - On 7/23/13, R65 struck a trained medication aide. - On 7/25/13, R65 was noted to have increased violet behavior. - On 8/2/13, R65 was noted to have a one centimeter cut on the left side of his head and the sink in the bathroom was found detached from	F 323		

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F 323	Continued From page 214 the wall. During August 2013, R65 was again noted to be pacing on the unit in and out of other resident rooms. - On 8/13/13, R65 was noted as agitated, shaking fist and growling and was started on direct observation. - On 8/15/13, R65 was noted to hit staff when being directed away from another resident who was yelling and was given Ativan for increased agitation. The admission MDS dated 2/4/13, indicated R65 had severely impaired cognitive skills for daily decision making, had physical/verbal and other behavior one to three days and wandered daily. A Social Services Meeting/Assessment Update dated 2/5/13, identified R65 as being verbally abusive and physically aggressive at times and identified R65 as wandering the unit without purpose. A Social Services Meeting/Assessment Update dated 5/8/13, indicated R65 continued to wander on the unit and physical aggression had been stable during the prior quarter. A Social Services Meeting/Assessment Update dated 7/9/13, indicated wandering/verbal and physical aggression were discussed with ongoing monitoring, working with wife needed for interventions and an order for occupational therapy for sensory stimulation. A Resident Incident Report dated 2/12/13, indicated R65 attempted to take food from another resident and the other resident struck R65, R65 then tipped the table over. The facility did not identify or put into place any interventions to minimize R65's behavior. A Resident Incident Report dated 5/14/13, indicated R65 was punched on the cheek by another resident when	F 323		

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R65 attempted to enter the other resident's room. The intervention was to re-direct R65 and use a "stop sign" on the resident's room. The re-direction had already put on the plan of care as an intervention. A Resident Incident Report dated 6/26/13, noted R65 struck another resident several times when the other resident attempted to get R65 out of his bed. The intervention put into place 30 minute checks for R65. There were no other interventions put into place to keep R65 safe.

The Behavior/Intervention Monthly Flow Records for 8/1 to 8/14/13, included target behaviors of agitation, wandering in rooms and aggressive behaviors for Zyprexa. The target behavior of agitation was documented as only occurring on the evening shift. The identified intervention for agitation was noted as offer food and fluids and was documented as effective. The target behavior of wandering in rooms was documented on the day and evening shifts as being continuous. The identified intervention on the day shift was noted as one on one and was noted as not being effective with no other interventions identified. The intervention noted for wandering on the evening shift was redirect and one on one which was documented as being effective on all days documented. Aggressive behavior was noted almost daily on the evening shift with identified intervention of redirect which was noted as effective. The intervention of one on one was added on 8/15/13, during the survey and was noted as being effective.

A physician's order dated 8/14/13, directed to discontinue Zyprexa (an antipsychotic), start Tylenol (a mild analgesic) twice a day, and start Seroquel (an antipsychotic medication) twice a

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F 323	Continued From page 216 day and start Ativan every six hours as needed for anxiety/agitation. Review of the Behavior/Intervention Monthly Flow Records started on 8/15/13, included target behaviors of wandering and agitation for Seroquel and physical aggression and physical outbursts for Ativan. When interviewed on 8/14/13, at 11:46 a.m. family member (F)-A stated staff were redirecting R65 more which was helpful. F-A stated on weekends, staff are observed in common areas and are not watching R65. On 8/14/13, at 6:23 p.m. the particulars with the abuse policy were reviewed with the administrator and DON. The facility policy did not identify how the facility was going identify, investigate, determine intent, and keep resident's safe from resident to resident altercations and what interventions were put in place to minimize potential harm from the altercation(s). The administrator stated the policy was an Ecumen corporate policy and they would need to have corporate make any changes to the policy. When interviewed on 8/19/13, at 9:56 a.m. RN-A stated the only indications for use or Zyprexa were eating other resident's food, pacing, laying in other resident's beds and resistive to cares. RN-A offered no other comments regarding R65's behavior. R65 continued to display physical aggression to others and himself due to the lack of a comprehensive assessment for the physical behaviors and lack of implementation and /or revision of interventions. R8's Resident Admission Record dated 1/10/08,	F 323		

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F 323	Continued From page 217 indicated R8 had diagnoses of adjustment disorder with depression, anxiety, convulsions, muscle spasm, infantile palsy, stroke with hemiplegia (loss or decreased use of one side of the body), contracture, dystonia (lack of muscle control), and narcissistic personality disorder with anti-social traits. The resident had a plan for extreme verbal and physical abuse to be removed from the facility by a call to 911 to send resident to the Hennepin County Medical Center (HCMC) crisis intervention unit. The facility lacked supervision to implement R8's behavior management plan and/or behavioral programing for R8 to prevent repeated verbal and physical abuse to staff and peers. R8 was observed on 8/12/13, at 1:00 p.m. the resident requested an interview with surveyor, stating his name was being slandered by a resident that said he had abused her. R8 was sitting at a dining room table watching a movie, with his puzzle books and mail on the table. On 8/12/13, at 8:00 p.m. R8 was observed to have a verbal outburst at the peer he said was slandering him, and became agitated, leaning forward repeatedly in his wheelchair, towards the peer, staff intervened and attempted to redirect the resident who continued his verbal outburst. R8 was again at a third floor dining room table watching a movie with his puzzle book nearby. On 8/14/13, at 6:00 p.m. R8 was observed to have a verbal outburst in the dining room on the third floor, during the dinner meal. The staff was not able to redirect R8 and the DON had to intervene to calm R8. The observation of the third floor dining room noted the room to be out of sight from the nurse's station. R8's care plan initiated 9/29/08, indicated R8 was	F 323		

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F 323	Continued From page 218 a vulnerable adult at risk for harm to self or others, inappropriate behavior and altered mood state related to nursing home placement, anger with staff, verbally abusive/name calling, refusing cares, disruptive behaviors in common areas, swearing and yelling in dining room, physically arguing with staff and others. R8 was very impulsive and easily angered by other residents, verbally abusive and resistive with cares, received anti-psychotic, anti-depressant, and anti-anxiety medication as needed. Resident had the tendency to perseverate on medical concerns, his eye glasses, etc. The interventions listed were to offer choices, remind him name calling was not appropriate or acceptable, attempt re-direction, and re-enforce his capabilities and competencies. Staff was to remove him to his room to calm down as needed, set limits with, leave him to cool off when he was verbally aggressive and check back and to remind him to speak softer. "Call 911 and send to crisis (intervention unit when needed). Leave more space between tables in the dining room and fellowship hall, discuss keeping the peace, listen to concerns, express appreciation for efforts to be a gentleman, re-enforce positive outcomes. Discuss his role as on advocate throughout his life; discuss how others have positively impacted his life. (Wife who passed away). Kill with kindness approach, psychology following as needed. Encourage him to do his puzzles. Inform resident's sister of behaviors. Complete vulnerability assessment per policy; continue to post abuse reporting form with staff and Hennepin Counties number. All staff [is] annually trained on abuse reporting." The care plan included reporting abuse to Hennepin County. The significant change MDS dated 6/7/13,	F 323		

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F 323	Continued From page 219 revealed a BIMS score of 11/15, which indicated moderate cognitive impairment and evidence of delirium - psychomotor retardation that comes and goes. R8 required extensive assistance and two person physical assist with bed mobility and transfers. Extensive assistance of one person for dressing, personal hygiene, toileting, and locomotion off the unit, was independent in locomotion on the unit. R8 had verbal behaviors directed towards others one to three days and physical behaviors one to three days. The CAA's dated 6/7/13, triggered behavioral symptoms, but that was not addressed in the CAA's narrative summary. The incident reports for R8 were reviewed from 8/27/12, going forward and the following was noted: - On 8/27/12, during an altercation over the television (TV) in the third floor dining room, R8 struck R78 on the hand leaving a 3.0 centimeter (cm) by 1.5 cm bruise. R78 stated he "was watching a TV program at 7:00 p.m. and R8 came into the dining room and wanted to watch TV, I told him I was already watching a program and would change it at commercial time, he started yelling at me so I tried to go back to my room, but he hit me on my hand!." R78 returned to his room and at 10:30 p.m. reported to the floor nurse that R8 had struck him. The report to the SA on 8/28/12 (one day late), indicated a RN responded to yelling in the dining room and saw a NA prevent R8 from charging R78. The investigative report was submitted 8/30/12, and R8 stated "I got so mad that I just hit him!" The report indicated R8 had a history of physical aggressive behavior towards staff and other resident's at the nursing home. R8 had both in house psychologist on an as needed basis and a	F 323		

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F 323	Continued From page 220 psychiatrist in the community. Stafffollowed the care plan; they are to protect residents and themselves, move other resident's away from R8 to safety and call 911 to send R8 to HCMC crisis unit if R8 was non-directable. SSD-A had also spoken with MD regarding alternative placement in the community that would better suit R8's behaviors. SSD-A will make a referral for relocation services for a more appropriate environment. - On 9/9/12, (untimed) incident R599 reported to staff that R599 attempted to help another resident pick something off the floor on ground level. R8 asked R599 to move out of his way. When R599 did not move fast enough, R8 became mad and elbowed R599 in the arm and attempted to push him out of the way. That was reported to the State agency on 9/10/12 (one day late). The investigative report submitted 9/13/12, indicated care plan interventions were followed for both verbal aggressive behaviors and physical behaviors. Residents were immediately separated and R8 was asked to lower his voice. R8 had other incidents at the facility. "(A) 911 protocol is in place for R8, staff was aware to contact 911 and send R8 to HCMC crisis unit if behaviors are unmanageable." SSD-A was in the process of requesting Hennepin County relocation services to assess to see if R8 was appropriate for group home setting. R8 was also seen by in house psychologist on 9/10/12, for behavior management. - On 12/3/12, at 4:20 p.m. R8 had an altercation with R54 who had requested to change the TV channel in the ground floor Fellowship Hall. R54 was near R8 who was acting out. R8 scratched R54 on the left shoulder and threatened to break R54's laptop. Staff immediately intervened and separated the residents. R54 was sent to his	F 323		

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F 323	Continued From page 221 room and R8 was sent out 911 to HCMC crisis unit for evaluation and the keep the other residents in the building safe. On 12/3/12, reports were made to Hennepin County, the SA and the police. The investigative report was submitted 12/7/12, and indicated R8 was admitted to HCMC and evaluated by the HCMC psychiatrist, medications were evaluated and changed. The resident returned to the facility on 12/5/12. R8 will be seen by in house psychiatrist every month for the next three to six months, HCMC was notified of change in care. SSD-A will continue to monitor resident's behavior and follow care plan interventions. The chart lacked documentation of monthly psychiatrist appointments. - On 12/31/12, a Minnesota Department of Health (MDH) report at 8:00 p.m. stated "R8 did not agree with other residents in the dining room that the TV channel should be changed and verbally threatened R76, another resident on 3rd floor that was present in the dining room. The two residents were immediately separated by staff and made safe. It was added to the nursing communication book to monitor R8 to prevent recurrence. Investigation has been initiated. On 1 /4/13, the follow-up investigation indicated staff working that night separated residents R8 refused to go to his room, the RN escorted him to his room. If the situation becomes un-manageable and unsafe for staff or resident's staff is aware to call 911 and have resident sent to HCMC for evaluation. See outside psych [sic], SSD-A attempting to get records so can be seen by in house psych [sic], also seen by in house psychologist. SSD-A will update in house psychologist on his next visit on 1/14/13 re more specific behavioral plan. The investigative report dated 1/1/2013, at 4:20 p.m. indicated resident to resident altercation. R8 got upset at residents who asked to have the channel	F 323		

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F 323	Continued From page 222 changed on ground floor TV in fellowship hall. R76 was near R8 when he was acting out; R8 scratched R76 on the left shoulder and threatened to break R76's laptop. Staff immediately intervened and separated the two residents to de-escalate the situation. Resident R76 was interviewed regarding what happened from his perspective and then immediately sent back to 1st floor to where his room is to separate him from R8. R8 was sent 911 out of the building for evaluation and to keep the other residents in the building safe. (Stated no evidence of previous incident by alleged perpetrator. A police report was made and 911 were called to send resident to HCMC crisis unit. R8 admitted to crisis unit and evaluation was done. R8 returned to the hospital. - On 1/5/13, resident was returned to facility pleasant and complaint. Seen by outside psychiatrist. Per NP request resident will be seen by in house psychiatrist every month for the next three to six months. Staff will continue to monitor and follow up care plans. The investigative report was submitted on 1/4/13, and indicated R8 was verbally threatening other residents, and has a personality disorder and was developmentally delayed. R8 can be verbally aggressive and disruptive with both residents and staff, this behavior has a history of escalating to being physically aggressive. (A) 911 intervention was in place which staff followed when resident refused to lower his voice, and refused to go to his room. He was escorted to his room. Staff was aware to call 911 and have R8 sent to HCMC for evaluation. Resident presently sees an outside physiatrist; SSD-A was in the process of getting all medical records from outside psychiatrist so resident can be seen by in house psychiatrist. R8 was also seen by in house psychologist, SSD-A will speak with in house psychologist regarding a	F 323		

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F 323	Continued From page 223 more specific behavior plan. - On 5/7/13, R8 had a medical admission to HCMC for pancreatitis and urosepsis. R8's aggressive behavior decreased to health conditions see significant change MDS above. - On 6/17/13 R8 had a medical admission to HCMC for increasing kidney failure and lethargy, and R8 was discharged back to the facility on 6/20/13, (discharge summary showed weight over past year gained 90 pounds (lbs.) of weight in one month and then dropped 100 lbs. over a 4 months period. was in increasing kidney failure decreased intake, lethargy. On 8/16/13, at 8:43 a.m. the SSD-A was interviewed and stated she was not aware of the physician comment that the facility was not the appropriate setting for R8, and stated she had been attempting to get ammunition to get a 30 day discharge. SSD-A stated she had requested a behavioral management plan for R8 and was told to move the other residents out of the dining room, but the other residents refused to go, because they are not doing anything wrong. SSD-A stated that R8 was very territorial and had refused to watch the TV in his room. SSD-A was not aware that R8's care plan did not address physical aggression other than the call to 911 to remove R8 from the facility. SSD-A further stated that when R8 acts out and SSD-A had restricted him to his room, but she will come back into the facility and find R8 in the dining room, because the plan (written in the communication book) had not been followed by staff. R8's behaviors dissipated when he was ill in May and June 2013. The facility had attempted to find other placement for him, but he refused and stated he wanted to be here and the family wants	F 323		

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F 323	Continued From page 224 him here and participates in care conferences, but say "how can he get away with this behavior." The psychologist's recommendation was to remove others from the environment, but they refuse since they are not misbehaving. When 911 was called, they do not always take him out to HCMC, if he refuses they leave him here.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide 1 of 1 resident (R68), reviewed for dialysis, with the recommended diet and dietary supplement as recommended by the dialysis program. Findings include: R68 was admitted to the facility on 8/17/11, and had diagnosis that included chronic kidney disease (Stage IV) and diabetes mellitus Type II. He attended dialysis three times weekly.R68 was identified at high nutritional risk and the staff did	F 325		

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F 325	Continued From page 225 not ensure he received the prescribed diet or nutritional supplement. On 8/14/13, at 8:30 a.m., during observation of personal cares, five packages of grahams crackers, seven packages of Oreo cookies, a 24 ounce container of diet Pepsi (3/4 empty and a 24 ounce container of orange soda (1/2 full) were observed on R68's dresser by his bed. In the opened dresser drawer were four unopened eight ounces containers of chicken noodle soup. One of the soups was dated 1/7/13, a second was dated 7/13/12 and two of them were undated. A chocolate chip cookie was lying on the resident's bedside table. In the metal basket on R68's wheeled walker were a four ounce unopened container of Jell-O, three bags of snack chips and three unopened eight ounce containers of Renal 2 Cal (a protein dietary supplement). The resident acknowledged all these items were his but would not confirm if they were an acceptable part of his dietary plan. R68 was served breakfast on 8/14/13 at 9:04 a.m. He was served two pieces of sausage, one piece of French toast, hot cereal, orange juice, 2% milk and coffee. Placed on his dietary tray was a card, which indicated R68 was not to have oranges, bananas, oatmeal, baked potatoes and cantaloupe. He was also not to have any added salt. R68 was served breakfast on 8/16/13, at 8:48 a.m. by NA-M. He was served one hardboiled egg, a piece of toast and a bowl of hot cereal. He was also served a glass of water, orange juice, skim milk and a cup of coffee. An interview with NA-M was done after she had finished serving the resident his meal. She reported she had	F 325	**F325** 1. Corrective Action: A) Resident #68 had his nutritional supplements needs reassessed and his care plan was updated. B) Resident #68 had his diet including foods to avoid and his fluid restriction reviewed and his care plan was revised. Dialysis team updated and agreed. 2. Corrective Action as it applies to other residents: A) All residents receiving dialysis have the potential to be affected by the same deficient practice. B) The nutritional and nutritional supplement needs and fluid needs of all new dialysis patients will be assessed and care plans updated appropriately C) Nursing and Dietary staff were educated on importance of following special diets and being compliant. 3. Date of Completion: 10/3/13	

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F 325	Continued From page 226 worked with the resident several times and felt she knew his needs fairly well. She indicated the resident was on no special diet and had no specific fluid restriction. She reported the only way she knew if the resident was on any special diet was to look at the diet card on the meal tray. She indicated she had done so and felt she had served R68 the correct meal. The care plan established on 9/24/12, noted R68 had the potential for alteration in nutrition related to the need for a therapeutic diet related to kidney disease with the need for dialysis three times a week, potential for weight loss and decreased appetite related to failure to thrive and depression, weight fluctuation due to the use of a diuretic. The dietary goal was the resident would maintain his weight at 165# or above. The established interventions were to provide R68 with the diet prescribed by the physician, medication and supplements as ordered by the physician. A nutritional assessment was last completed on by the certified dietary manager (CDM) on 6/21/13, and documented R68 was a regular diet, no added salt and low protein diet with 2000 milliliter (ml) fluid restriction and was compliant with dietary plan "most of the time." The assessment reported R68 was consuming 2000 ml or less. R68 was considered at medium risk for nutrition and hydration. The Care Area Assessments (CAAs) completed on 7/12/13, and indicated the staff had noted a decline in the resident mobility and he had been hospitalized from 6/11/13 to 6/14/13. They noted some improvements in some care areas but determined the resident had declined overall and	F 325	4. Recurrence will be prevented by: A) Random audits will be completed weekly x4 then monthly x3 with results being presented to the QA Committee for follow up discussion/planning. 5. Completion will be monitored by: Director of Nursing or Designee	

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F 325	Continued From page 227 due to his potential for skin breakdown, continued need for assistance with transfers and the potential/expectation he would continue to have variations in mobility. It was also documented his status was variable related to his medical condition, dialysis, fragile status and periods of increased weakness and as result a significant change assessment was completed. The nutritional CAA noted R68 had the potential for alteration in nutrition related to the need for a therapeutic diet. A progress note, written by the consultant dietician on 7/12/13, indicated R68 remained on no added salt, low potassium, 2000 ml fluid restriction diet. He had good intakes of foods at most meals and she made no recommendations for any dietary changes. A significant change Minimum Data Set (MDS) was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. He needed extensive assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene. Once his meal was set up by staff, he was able to eat independently. R68 had a physician's order, last reviewed on 8/1/13, for a no added salt diet which was low in potassium and 2000 ml fluid restriction. He also had an order for Torsemide 20 milligrams (mg), two tablets twice a day for diuretic therapy. In addition, R68 had a physician order for eight	F 325		

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F 325	Continued From page 228	F 325		

ounces of Nepro (a nutritional supplement daily for dialysis residents) which was written on 7/16/13.

An interview with nursing assistant (NA)-B reported on 8/14/13, at 9:15 a.m. was completed. A review of the dietary card was done with NA-B, which indicated R68 was not to have orange juice that was served. NA-B acknowledged she was to check the resident's dietary card for any special instructions and acknowledged she had not done this prior to serving the resident. She removed the orange juice and replaced it with 120 cubic centiemeters (cc) of apple juice. She reported after the resident eats his meal and consumes his fluids, she would document his intake on a Food and Fluid Intake Record. She reported being aware that resident was on a fluid restriction but not aware of the amounts. She reported the Nursing Assistant Care Sheet would tell her of any special diet, but did not have one.

An interview was completed with the certified dietary manager (CDM) on 8/14/13, at 9:20 a.m. She reported R68 was on a no added salt, low potassium diet with 2000 cc of fluid restrictions. She indicated that generally the resident was cooperative with the dietary plan and restriction. She reported nursing staff are responsible for monitoring the food/fluid intake of the resident. A review of the food/beverage items observed in the resident's room on 8/14/13 was reviewed with the CDM, who reported she would expect the nursing assistants to report this to the charge nurse, but unsure if this happened. She reported she was not aware of the resident "hoarding" food/beverages in his room and she indicated she should have been informed of this behavior. The DCM indicated the resident could have orange

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F 325	Continued From page 229 juice but not oranges. She also indicated although, he could not have baked potatoes, he could have mashed potatoes. She indicated the baked potatoes was not part of the potassium restriction, it was a personal preference. An interview on 8/14/13, at 1:33 p.m. with the Dialysis Dietician (DD) was completed. She reported R68 was to be on a renal (Dialysis) diet which is to include increased protein, low potassium, low sodium and low phosphorus and facility staff were to also monitor and restrict the fluid intake. She indicted she was not aware the resident was on a regular diet, low sodium/potassium diet with 2000 cc fluid intake but felt that it was acceptable. She reported that the facility did not contact her in consultation and if any contact was made, she needed to call the facility. She reported she talked to the CDM on a monthly basis and had offered to do dietary training with the facility staff regarding the appropriate dietary plan for R68 as was concerned that he was getting a diet that was too high in potassium but the facility had declined the offer. She indicated R68 was to receive a diet that avoided potatoes, tomatoes, bananas, oranges and orange juice. An interview with the facility's consultant dietician (RDC) was completed on 8/15/13, at 1:58 p.m. She reported she came to the facility monthly and oversaw dietary services for R68. She indicated the resident's diet was liberalized in efforts to attempt to have the resident more compliant with dietary plan. She reported in the past, the resident was very non-compliant with dietary plan. She reported she had provided the resident with educational materials on foods that were high in potassium and health consequences of	F 325		

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F 325	Continued From page 230 consuming foods that were high in potassium but she questioned the resident's receptiveness to the educational materials. She denied any contact with the dialysis dietician or any knowledge of offers of additional dietary training for the staff. A second interview with the CDM was completed on 8/16/13, at 1:15 p.m. She reported the dialysis dietician had offered to do dietary training for the facility staff but she had declined this offer as she felt the resident was doing well with the current dietary plan. Nutritional Supplement On 7/11/13, the dialysis program recommended the resident be provided with eight ounces of Nepro nutritional supplement daily. The recommendation was noted by the facility on 7/16/13 and a physician order was received. Three unopened containers of Nepro were observed in the basket R68's rolling walker on 8/14/13, at 8:30 a.m. An interview with licensed practical nurse (LPN)-D was completed on 8/14/13, at 9:45 a.m. She reported she thought the resident was receiving a nutritional supplement and it was an expectation if the supplement was given to the resident, staff observes the resident drinking it. A review of the Medication Administration Record (MAR) was completed with licensed practical nurse (LPN)-A on 8/19/13, at 9:37 a.m. LPN-A was unable to find evidence in the MAR of the physician order or that the resident was receiving the ordered nutritional supplement. An interview with registered nurse (RN)-A was	F 325		

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F 325	Continued From page 231 completed on 8/19/13, at 9:40 a.m. She verified the MAR did not reflect the physician order for the nutritional supplement and there was no evidence the resident was receiving the supplement. She also verified the nursing staff was responsible for administering the supplement.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor and provide with sufficient fluid intake to maintain proper hydration and health for 1 of 1 resident (R68) in the sample who received dialysis services. Findings include: R68's Resident Admission Record dated 8/17/11, listed the diagnosis as chronic kidney disease (Stage IV). He attended dialysis three times weekly. R68 was identified to have a high nutritional risk as was on dialysis, had 2000 cubic centimeters (cc) fluid restriction and was on a diuretic. R68 was at risk for dehydration and the facility lacked evidence they were monitoring his fluid intake. On 8/14/13, at 8:30 a.m. during observation of personal cares, five packages of grahams crackers, seven packages of Oreo cookies, a 24	F 327	**F327** 1. Corrective Action: A) Resident #68 had his nutritional supplements needs reassessed and his care plan was updated. B) Resident #68 had his diet and his fluid diet reviewed and care plan was revised. Dialysis team updated and agreed. 2. Corrective Action as it applies to other residents: A) All residents receiving dialysis have the potential to be affected by the same deficient practice. B) The nutritional and nutritional supplement needs and fluid needs of all new dialysis patients will be assessed and care plans updated appropriately C) Nursing and Dietary staff were educated on importance of following special diets and being compliant.	

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F 327	Continued From page 232 ounce container of diet Pepsi (3/4 empty), a 24 ounce of orange soda, were observed on R68's dresser by his bed. In the opened dresser drawer were four unopened eight ounces containers of chicken noodle soup. One of the soups was dated 1/7/13, a second was dated 7/13/12, and two of them were undated. A chocolate chip cookie was lying on the resident ' s bedside table. In the metal basket on R68's wheeled walker were a four ounce unopened container of Jell-O, three bags of snack chips and three unopened eight ounce containers of Renal 2 Cal (Calorie- a protein dietary supplement). The resident acknowledged all these items were his but would not confirm if they were an acceptable part of his dietary plan. R68's dining was observed on 8/14/13, at 9:04 a.m. The resident's meal was sent to the nursing station, prepared by the dietary staff and nursing assistant (NA)-B served R68 a bowl of hot cereal, a slice of French toast and two sausage links. NA-B also served R68, 240 cc of milk, 120 cc of orange juice and 180 cc of coffee, which she had prepared for him. The resident ate his meal independently after he was served. On the meal tray was a diet card that indicated "Can't have oranges, bananas, oatmeal, bake potatoes or cantaloupe. No salt." NA-B reported on 8/14/13, at 9:15 a.m. R68 was not to have orange juice, even though she had given it to him. She reported she was to check his dietary card for any special instructions and acknowledged she did not do so prior to serving the resident. She removed the orange juice and replaced it with 120 cc of apple juice. She reported after the resident eats his meal and consumes his fluids, she would document his intake on a Food and Fluid Intake Record. She reported being aware	F 327	3. Date of Completion: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x4 and then monthly x3 with results being presented to the QA committee for follow up discussion/planning. 5. Completion will be monitored by: Director of Nursing or Designee	

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F 327	Continued From page 233 that resident was on a fluid restriction but not aware of the amounts. She reported the Nursing Assistant Care Sheet would tell her of any special diet, but did not have one. Breakfast was served on 8/16/13, at 8:48 a.m. by NA-M. R68 was served one hardboiled egg, a piece of toast and a bowl of hot cereal. He was also served 240 cc of water, 120 cc of orange juice, 240 cc of milk and 180 cc of coffee. An interview with NA-M was done after she had finished serving the resident his meal. She reported she had worked with the resident several times and felt she knew his needs fairly well. She indicated the resident was on no special diet and had no specific fluid restriction. She reported the only way she knew if the resident was on any special diet was to look at the diet card on the meal tray. She indicated she had done so and felt she had served R68 the correct meal. The plan of care established on 10/3/12, indicated R68 did have the potential for alteration in fluid balance due to chronic kidney disease and hypertension and the staff identified R68 as being a risk for dehydration. The care plan directed staff to administer the resident's medication as ordered by the physician, observed for side effects and effectiveness of the medication, vital signs and weights were to be done as order by the physician (before and after dialysis), labs as the physician ordered and observed for signs and symptoms of dehydration such as poor skin turgor, dry mucus membranes and tachycardia. In addition, the resident was on 2000 milliliter (ml) fluid restriction. The plan of care was revised on 5/9/13, and noted R68 refused to follow fluid restriction and purchased his own food and fluid.	F 327		

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F 327	Continued From page 234 Staff was directed to explain risk versus benefit to the resident. A nutritional assessment was last completed on by the certified dietary manager (CDM) on 6/21/13, and documented R68 was a regular diet, no added salt and low protein diet with 2000 ml fluid restriction and was compliant with dietary plan "most of the time." The assessment reported R68 was consuming 2000 ml or less. R68 was considered at medium risk for nutrition and hydration. The Care Area Assessments (CAAs) completed on 7/12/13, and indicated the staff had noted a decline in the resident mobility and he had been hospitalized from 6/11/13 to 6/14/13. They noted some improvements in some care areas but determined the resident had declined overall and due to his potential for skin breakdown, continued need for assistance with transfers and the potential/expectation he would continue to have variations in mobility. It was also documented his status was variable related to his medical condition, dialysis, fragile status and periods of increased weakness and as result a significant change assessment was completed. They noted a problem with balance during transition and ambulation but at other times, R68 was able to stabilize himself without staff assistance. He was frequently incontinent of bowel and bladder. He ambulated with the use of a wheeled walker but staff documented an expectation the resident's ambulation was expected to change due to increased periods of weakness and he may need to use a wheelchair at times. Even though he had periods where his balance was an issue, he had had no falls. The nutritional CAA noted R68 had the potential for alteration in nutrition related to	F 327		

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F 327	Continued From page 235 the need for a therapeutic diet. The CAA did not address the resident's risk for dehydration. The last progress note, written by the consultant dietician was on 7/12/13, and noted the resident remained on a no added salt, low potassium, 2000 ml fluid restriction diet with good intakes noted at most meals. She made no recommendations for any dietary changes. A significant change Minimum Data Set (MDS) was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. He needed extensive assistance of one staff with bed mobility, transfers, dressing, toilet use and personal hygiene. The Food and Fluid Intake Record for July 1 to July 31, 2013. Eleven days during that time, the documentation was incomplete. The daily intakes of fluids ranged from 240 cc to 1780 cc. No documentation was found of the resident's fluid intake at other times, other than meals. The Food and Fluid Intake Record for R68 for August 1 to August 14, 2013 were reviewed. Six of the days were incomplete and indicated for the noon meal the resident was on a LOA (leave of absence). The daily intakes of fluids ranged from 780 cc to 1480 cc per day. No documentation was found of the resident's fluid intake at other times, other than meals. R68 had a physician's order, dated 8/1/13, for a	F 327		

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F 327	Continued From page 236 2000 ml fluid restriction and an order for torsemide 20 milligrams (mg), two tablets twice a day for diuretic therapy. The Medication Administration Record (MAR) for August, 2013 was reviewed. Documentation was found of the fluids R68 consumed at meals, but no documentation was found on other liquids the resident drank. There were also no totals of daily amounts the resident consumed. An interview was completed with the CDM on 8/14/13, at 9:20 a.m. She reported R68 was on a no added salt, low potassium diet with 2000 cc of fluid restrictions. She indicated that generally the resident was cooperative with the dietary plan and restriction. She reported nursing staff are responsible for monitoring the fluid intake of the resident. She also reported that no plan had been developed specifying how much fluid nursing staff could give R68 and how much fluid dietary can give the resident. She also reported felt the resident fluid intake did not go over the prescribed amount but review of the record lacked any evidence of dietary tabulating the amount of fluids the resident consumed. A review of the food/beverage items observed in the resident's room on 8/14/13, was reviewed with the CDM, who reported she would expect the nursing assistants to report this to the charge nurse, but unsure if this happened. She reported she was not aware of the resident "hoarding" food/beverages in his room. An interview with licensed practical nurse (LPN)-D on 8/14/13, at 9:45 a.m. was completed. She reported that every shift the nurses document on the MAR how much fluid the resident drank during each meal. She also	F 327		

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F 327	Continued From page 237 reported they did not monitor how much fluid the resident drank during medication administration or throughout the day. The facility's policy Dialysis (Program Guidelines) review date of 8/13/13, did not address the monitoring of fluid intake, which would include both the food/fluids served by the dietary staff and fluids consumed during medication pass and at various times throughout the day on the nursing station.	F 327		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329** 1. Corrective Action: A) Resident #45 had a medication review completed and his target behaviors and indications for use of Depakote have been revised. His other psychotropic medications (Prozac and Remeron) were also reviewed related to indications for use and target behaviors. His care plan was reviewed and revised.	

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F 329	Continued From page 238 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 6 of 8 residents (R45, R35, R68, R87, R65, R49) were free of unnecessary medications. Findings include: R45 received Depakote (a seizure medication, also used as a mood stabilizing medication) without adequate indications for the use of the medication. In addition, the facility did not establish appropriate target behavior monitoring and care planning for the use of the medication. The Resident Admission Record indicated R45 was admitted to the facility on 9/19/12, with diagnoses to include vascular dementia, persistent mental disorder, and depressive disorder. The annual Minimum Data Set (MDS) dated 9/25/12, indicated R45's a Brief Interview of Mental Status (BIMS - a tool used to measure cognition) score could not be completed and identified R45 had short and long-term memory impairments; R45 required physical assistance with all Activities of Daily Living (ADLs). The Care Area Assessment (CAA)Cognitive Loss/Dementia dated 9/25/13, identified R45's cognitive losses and that R45 was not independent with decision making skills, that R45 was inattentive, had disorganized thinking, physical behaviors towards others and rejection of cares. The CAA identified R45 had "a difficult time adjusting to the move" and identified specific physical behaviors, suicidal risk and referral to the psychiatrist. The CAA for Falls/Psychotropic Medication Use dated 10/2/12,	F 329	B) Resident #35 had a medication review completed and his target behaviors and indications for use of Trazadone, Paxil and Wellbutrin SR were reviewed and revised. Currently being reviewed by psychiatrist for possible reduction. C) Resident #68 medication has been reviewed and reduced per recommendation. D) Resident #87 had a medication review completed and her fall risks have been reassessed. Her target behaviors and indications for use of Celexa and Risperidone were reviewed and revised. Her care plan has been reviewed and revised. The MAR/TAR reflects the need to monitor orthostatic blood pressures monthly and the nursing staff was educated on the need to complete this. The physician and pharmacist have reviewed her psychotropic medications.	

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F 329	Continued From page 239 indicated R45 received the antidepressant Prozac for depression. A care plan dated 10/9/12, identified R45 was at risk for side effects from psychotropic drug use and identified R45 received "antidepressant med [medication]." The care plan did not include the use of Depakote. Doctor's Order Sheets indicated the following: - On 7/19/13, Depakote 125 milligrams (mg) by mouth (PO) twice daily (BID) was started for the diagnosis of anxiety; - On 7/30/13, the Depakote was increased to 250 mg PO BID for the diagnosis of anxiety. Review of the June, July and August 2013 Behavior/Intervention Monthly Flow Records indicated the following: - The June record identified target behavior for mood monitoring for the Prozac and Remeron (antidepressant) was to be completed. Although the behavior sections of the sheets were blank, the evening shift had documented no mood behaviors. The day and night shift documentation was blank. - The July record identified the target mood monitoring for Prozac was increased sadness and tearfulness. The target mood monitoring for Remeron was increased isolation. The clinical record lacked target behavior mood monitoring for the use of Depakote. - The August record included monitoring for Depakote was increased isolation, increased agitation/verbally abusive; target behavior monitoring for Remeron was "depression;" the target behavior for mood monitoring for Prozac was increased sadness and increased	F 329	E) Resident #65 had the use of Seroquel and Ativan reviewed (Zyprexa discontinued on 8/14/13). The target behaviors and indications for use were reviewed and revised and the care plan was updated. PRN Ativan is being monitored for effectiveness after administration. Orthostatic blood pressures are being monitored monthly on the MAR/TAR. F) Resident #49 had the use of Seroquel, Ativan and Zolpidem reviewed and the indications for use and target behaviors were revised. The care plan was updated.	

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F 329	Continued From page 240 tearfulness. The mood monitoring did not include resident specific target mood/behavior monitoring to determine indications for the use of the medications. On 8/15/13, at 1:31 p.m. the registered nurse manager (RN)-A stated the diagnosis for Depakote was "anxiety" and verified target behaviors needed to be monitored for were not resident specific. RN-A was unclear on the indication for the use of Depakote. RN-A stated "agitation" was monitored for and explained the target behaviors being monitored for were the same as for Remeron/Prozac. On 8/16/13, at 9:30 a.m. when asked about behavior monitoring, reporting of behavior or mood problems and target behavior monitoring the social service designee (SSD)-A stated, "My involvement has been limited." SSD-A verified she completed the mood and behavior sections of the care plan and confirmed the care plan did not address R45's resident specific target behavior monitoring for the use of Depakote. SSD-A stated it was a team effort to address behaviors, but then stated, "[We] currently have no behavior program here. It's being implemented. I need help on how to gather the information and then run with it." On 8/19/13, at approximately 1:30 p.m. the director of nursing (DON) verified the above findings and confirmed a diagnosis of anxiety was not an indication for the use of Depakote, the use of the Depakote should have been care planned and R45 should have been monitored for the use of the medication.	F 329	2. Corrective Actions at it applies to other residents: A) All residents on psychotropic medications have the potential to be affected by the same deficient practice. B) The target behaviors/indications for use and care plans of all residents receiving psychotropic medications were reviewed and revised as necessary. C) Drug regimen review recommendations have been sent to the physicians for response. D) Orthostatic BP's have been added to the MAR/TAR for the residents who require this monitoring C) Nursing staff has been educated on the protocol for Medication Review Policy, Psychotropic Medication Policy, Behavior Monitoring Policy, the need to check orthostatic blood pressures as ordered, and using medications appropriately for target behaviors. . 3. Date of Completion: 10/3/13	

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F 329	Continued From page 241 R35 was not monitored for resident specific target mood/behavior to determine the efficacy of Paxil, Trazodone and Wellbutrin SR (slow release-all antidepressant medications with different mechanisms). The Diagnoses Report - Clinical dated 3/31/11, indicated R35 had the following diagnosis: dementia, and depression with anxiety. The annual MDS assessment dated 2/13/13, indicated R35's BIMS score was 12, identified no changes with ADLs. The MDS identified impairment in both lower extremities. The MDS identified R35's PHQ-9 score (a tool used to determine potential depression) was one (low potential for depression) due to feeling down, depressed, or hopeless two to six days (several days) during the assessment period. The MDS identified R35 had no behavioral concerns. The CAA for Falls/Psychotropic Medication use dated 2/27/13, identified R35 received an "antidepressant medication." The CAA indicated R35 received "Trazadone, Paxil & Wellbutrin for depression." The CAA indicated, "He is monitored for med [medication] side effects & observed for med effectiveness. His mood has been stable." The CAA identified R35's psychiatrist and psychologist and indicated, "No referrals are needed at this time." The quarterly MDS dated 5/14/13, indicated R35 had a BIMS score of 13 (mild impairment). The MDS indicated R35's PHQ-9 score had improved and was now zero and indicated R35 had not behavior concerns. The Physician's Orders dated 7/28/13, directed to offer: - Paxil one 40 mg tablet by PO daily for the	F 329	4. Recurrence will be prevented by: Random weekly audits x4 then monthly x3 with findings being presented to the QA committee for follow up/planning. 5. Completion will be monitored by: Director of Nursing or Designee	

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F 329	Continued From page 242 diagnosis of "Depression." The Paxil was started on 12/20/12. - Trazodone half of a 50 mg tablet (25 mg) PO daily at bedtime for diagnosis of "Depression." The Trazodone was started on 12/20/12. - Wellbutrin SR one 200 mg tablet PO BID for diagnosis of "Depression." The Wellbutrin was started on 5/23/12. The care plan dated 3/15/10, indicated R35 was at risk for side effects from psychotropic drug use, such as hypotension (low blood pressure), movement disorder, gait disturbance (R35 was non ambulatory) and cognitive/behavior changes related to his diagnosis of "depression." The care plan identified the use of Paxil, Trazodone and Wellbutrin for "depression & Trazadone [sic] for Insomnia." The care plan identified, "His mood has been stable." An undated hand written update directed, "See Behavior/intervention monthly flow record for S/E [side effects]." The care plan identified goals of "no negative outcomes resulting from psychotropic medications" and "he will sleep at least 6 hours/night." The care plan directed: observe for med effectiveness and monitor for side effects; observe for drug related cognitive/behavioral impairment, such as delirium symptoms; observe for constipation, update the physician as needed, orthostatic blood pressures per facility protocol, observe for insomnia and difficulty sleeping; provide a quiet, calm environment. Although the care plan identified the above, the care plan did not identify resident specific target mood indicators related to the use of Paxil and Wellbutrin Sustained-Release (SR). The undated Nursing Assistant Assignment Sheet AM/PM indicated, "Demanding - verbally abusive	F 329		

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F 329	Continued From page 243 when care not provided when he wants it done." The sheet indicated, "Report non-compliance with cares to nurse." The Behavior/Intervention Monthly Flow Records for June, July, and August 2013 indicated the following: - The record for June directed licensed staff to monitor for "depression symptoms" with intervention of "Refer to S.W. [social service designee]" for the use of Paxil. The month of June documentation was all "0's." Although a second monitoring record for Trazodone was blank for behaviors to be monitored for, "0's" were documented 13 times during the evening shift and twice on the night shift. The clinical record lacked evidence of behavior/mood monitoring for the use of Wellbutrin SR. - The record for July directed licensed staff to monitor for "Depression" with intervention of "Refer to S.W." for the use of Paxil. The month of July documentation was all "0's." Two more monitoring records for Trazodone and Wellbutrin SR were included with the monitoring, but were both blank. The clinical record lacked evidence R35 was monitored for sleep in July. - The record for August directed licensed staff to, "Document # [number of] hrs [hours of] sleep" for Trazodone. The documentation was of "0's" for the partial month of August and the number of hours R35 slept was not documented. Two monitoring records for Wellbutrin SR and Paxil directed licensed staff to monitor for "S/S [signs and symptoms of] Depression." The documentation was all "0's" for the partial month of August. The Behavior/Intervention Monthly Flow Records lacked monitoring for resident specific depression symptoms, such as but not limited to irritable mood or refusal/rejection of	F 329		

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F 329	Continued From page 244 care. The records indicated R35 was not consistently monitored for efficacy of Trazodone for sleep. In addition, the clinical record lacked evidence R35 was comprehensively assessed to determine monitoring for the concurrent use of two antidepressant medications (Wellbutrin SR and Paxil) which were both prescribed for the diagnosis of depression. On 8/15/13, at 1:31 p.m. the RN-A stated verified the target behaviors needed to be monitored for were not resident specific. RN-A was unclear on the indication for the use of Wellbutrin SR and Paxil. RN-A verified sleep monitoring was not consistent and the number of hours of sleep was lacking. On 8/16/13, at 9:30 a.m. when asked about behavior monitoring, reporting of behavior or mood problems and target behavior monitoring the SSD-A stated, "My involvement has been limited." SSD-A verified she completed the mood and behavior sections of the care plan and confirmed the care plan did not address R35's resident specific target behavior monitoring for the use of Paxil, Wellbutrin SR and Trazodone. SSD-A stated it was a team effort to address behaviors, but then stated, "[We] currently have no behavior program here. It's being implemented. I need help on how to gather the information and then run with it." On 8/19/13, at approximately 1:30 p.m. the DON verified resident specific target behaviors should have been monitored for the use of the antidepressant medications. R68's Resident Admission record dated 8/17/11, indicated R68 had diagnoses that included chronic kidney disease (Stage IV) and adult	F 329		

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F 329	Continued From page 245 failure to thrive. R68 was on Effexor 75 mg at bedtime for depression since 5/17/12. No evidence was found of the resident's physician had considered a dose reduction of the medication. A significant change MDS was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. Quarterly MDS's were completed on 3/22/13 and 6/21/13, and both assessments noted the resident had no problems with depression. The CAA completed on 7/12/13, noted the resident declined to participate in the assessment process. She indicated the resident did have disorganized thoughts and was inattentive. The CAA also noted R68's mood was stable and he was seen by the facility psychologist as needed. During the monthly medication review on 4/22/13, the consulting pharmacist questioned the need for a dose reduction of the Effexor. The pharmacist also noted on his pharmacy note of 5/28/13, of the antidepressant not being decreased. A note, written by the facility nurse practitioner on 5/2/13, requesting the physician evaluate the resident's depression and trial dose reduction. Staff was instructed to review the medication with the resident's physician during his next visit but no later than two months.	F 329		

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F 329	Continued From page 246 R68 was seen by his physician on 6/6/13 and 8/9/13, and evidence was not found of the physician reviewing the medication for appropriateness or considering a dose reduction. An interview with the DON on 8/19/13, at 12:16 p.m. was completed. She verified that physician should have reviewed the recommendations made by the pharmacist. The undated facility's policy Medication Regimen Review (Monthly Report), specified the consultant pharmacist was to review the medication regimen of each resident at least monthly. The policy directed staff to ensure recommendations are acted upon and documented by the facility staff and/or the prescriber. R87's Resident Admission Record dated 12/5/12, included diagnoses of dementia, insomnia, anxiety, hypertension and paranoid state. The facility did not establish appropriate target mood/behavior monitoring and care planning for the use of the medication. During observation on 8/14/13, at 3:07 p.m. R87 was noted to wander on the unit entering and exiting rooms. When R87 observed R82 sitting in room 214 (a third resident's room), R87 entered 214 and stayed with R82. The wandering care plan dated 12/13/12, directed staff to invite R87 to special events, give manicures, escort to room, give hand massages, call resident by name and wander guard. A physician's order dated 12/14/12, directed okay to be seen by in-house psychologist/ psychiatrist. Review of R87's record did not reveal any psychiatric notes.	F 329		

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F 329	Continued From page 247 The admission MDS dated 12/18/12, indicated R87 had both short and long term memory problems, moderately impaired cognitive skills for daily decision making and a score of three for staff identification of mood indicators (minimal depression). The quarterly MDS dated 6/7/13, indicated R87 had severely impaired cognitive skills for daily decision making. R87 was noted to wander daily, have no delusions or hallucinations and staff identified no mood indicators. The psychotropic medication care plan dated 12/24/12, indicated diagnoses for medication use as insomnia, depression, anxiety and dementia and identified hypotension and gait disturbance as possible side effects. R87 had a fall on 1/1/13, according to the Resident Incident Report dated 1/1/13. The report did not identify Trazadone as a potential cause of the fall. The only medication noted as a possible contributing factor was Lasix (a diuretic). The Resident Incident Report included a place for orthostatic blood pressure, however, of the twelve falls R87 had from 1/1/13 through 7/11/13, only two of the 12 falls had an orthostatic blood pressures recorded. A physician's order dated 1/11/13, directed to discontinue Trazadone due to fall after first dose. A Mood Interview was completed for R87 on 3/8/13, and indicated no signs or symptoms of depression were noted. A nurse practitioner (NP) progress note dated 4/22/13, indicated R87 had increased pacing but no delusions and Risperidone (an antipsychotic medication) was changed to as needed. A	F 329		

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F 329	Continued From page 248 physician's order dated 4/22/13, directed to discontinue Risperidone scheduled and give Risperidone 0.25 mg daily as needed times thirty days for paranoia, if needed please document in the nurse's notes and update the physician. Review of the April 2013 and May 2013 MAR revealed R87 did not receive any as needed Risperidone from 4/22/13 through 5/6/13. The following was noted for the scheduled psychotropic medication: Celexa: The April 2013 Behavior/Intervention Monthly Flow Record revealed target mood for Celexa (an antidepressant medication) resistive to cares. The target mood identified was noted as occurring daily with noted interventions of redirect and one on one which were noted as effective. The May 2013 Behavior/Intervention Monthly Flow Record revealed target mood for Celexa as pacing and in and out of other rooms. The target mood identified were noted as occurring daily with noted interventions of redirect and one on one which were noted as effective. Risperidone: The April 2013 Behavior/Intervention Monthly Flow Record revealed the behavior monitored for Risperidone was pacing in and out of other resident rooms which were noted as occurring daily. The interventions noted as used were redirect and one on one which were noted as being effective. The May 2013 Behavior/Intervention Monthly Flow Record revealed the behavior monitored for Risperidone as pacing in hallway which was	F 329		

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F 329	Continued From page 249 noted as occurring daily. The interventions noted as used were redirect and one on one which were noted as being effective. A physician's order dated 5/6/13, included Risperidone 0.25 mg every bedtime and as needed daily. Nurse's Notes were reviewed from 5/12/13 going forward and the following was noted: - On 5/12/13, R87 "woke up once to pace as it's what she does best." - On 5/13/13, noted R87 paced until 12:00 a.m. until talked into going to bed and was up twice more before going to sleep, - On 5/14/13, was noted up most of the night, on 6/2/13, indicated R87 had been up all night, - On 6/5/13, indicated R87 was continually pacing and - On 6/7/13, R87 was noted to have been pacing until 11:45 p.m. A Pharmacy Services Monthly Review dated 5/28/13, indicated to follow-up on Celexa gradual dose reduction (GDR). The irregularity report for the Celexa GDR was requested and was not provided. A mood interview completed for R87 dated 6/7/13, noted no indicators of depression. A Social Service Meeting/Assessment Update dated 6/12/13, indicated R87 continued to wander but is easily re-direct able, mood was stable and had no signs or symptoms of depression. A NP progress note dated 7/16/13, indicated the trial dose reduction for R87 was not successful and included the reasons included increased	F 329		

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wandering/pacing and decreased sleep at night. The NP note indicated staff had reported R87 was calmer and had decreased pacing since Risperidone was restarted and indicated R87 was "sitting more as her friend who paces no longer ambulates." The NP note indicated no reports of anxiety or depressive symptoms.

The Patient Medical Care Plan dated August 2013, indicated Risperidone was being given for paranoia/delusions and Celexa was being given for major depression. Review of the medical records revealed R87 was not being monitored for paranoia, delusions or depression.

When interviewed on 8/14/13, at 1:10 p.m. the DON verified there had been no monthly orthostatic blood pressure monitoring for R87.

When interviewed on 8/19/13, at 9:56 a.m. RN-A verified R87 had not been monitored for signs and symptoms of depression and the only indications for the Risperidone use were pacing, in and out of other resident rooms and resistive to cares.

The NP was interviewed on 8/19/13, at 11:10 a.m. regarding Risperidone and Celexa use for R87. The NP stated R87 had a long standing history of depression including tearfulness, anxiousness and knew she was not with her daughter. The NP noted with the trial off Risperidone, R87 had increased pacing, not sleeping and increased falls. The NP stated with the Risperidone restarted R87 had no tears and interacted better with her peers. The NP stated R87 had "paranoia" of going to bed and was afraid to be in bed and she wanted R87 to be comfortable not just sedated. When asked if she knew the PRN

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Risperidone had not been used as ordered after the scheduled Risperidone had been discontinued, the NP stated the nurses were just trying to "tolerate" R87's behaviors. The NP stated R87 was a "big fall risk" and the NP had to "be careful what to use for her [R87]."

R65's Resident admission Record dated 1/22/13, indicated R65 had diagnoses to include dementia, alcohol abuse, depressive disorder, Alzheimer's disease, osteoarthrosis and history of brain injury. The facility did not establish appropriate target behavior monitoring and care planning for the use of the medication.

The History and Physical (H&P) dated 11/26/12, indicated for R65 "the benefits of antipsychotic medication outweighs the risk of using neuroleptics in patients with dementia" and directed to avoid lorazepam (Ativan) due to paradoxical agitation. The H&P dated 11/26/12, also indicated R65 was taken off Keppra for seizures as it was known to cause "agitation/behavioral problems and even psychosis in some patients."

A psychiatry note dated 1/20/13, indicated R65 had severe dementia, potential delirium related to a urinary tract infection. The psychiatry note also indicated R65 received Zyprexa (anti-psychotic) in the late afternoon related to a history of sun downing agitation, received as needed Zyprexa with little effect, was noted to have been pacing around the unit and did not appear to be in distress.

The Cognitive Loss/Dementia CAA dated 1/29/13, identified R65 as having had episodes of both

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F 329	Continued From page 252 physical and verbal aggression, wandered on the unit which included into other resident rooms. The admission MDS dated 2/4/13, indicated R65 had severely impaired cognitive skills for daily decision making, had physical/verbal and other behavior one to three days and wandered daily. The altered thought process care plan dated 2/11/13, identified R65 wandered without purpose and directed to allow for safe wandering in an uncluttered environment and re-approach if resistive. A Consultant Pharmacist's Medication Review dated 4/22/13, recommended review of the Zyprexa dose for R65 and indicated "when Zyprexa is used for behavioral management due to dementia- the recommended max Zyprexa dose is 7.5 mg/day [milligrams]." The physician signed the Consultant Pharmacist's Medication Review on 5/7/13 and did not include a response if the recommendation was accepted or rejected. Review of the Medication Regimen Review for R65 did not include any follow-up from the pharmacist regarding the lack of response from the physician regarding the Zyprexa recommendation written on 4/22/13. Review of the April 2013, MAR revealed R65 was administered Zyprexa 10 mg per day (2.5 mg above the recommended amount) and received the 5 mg as needed (PRN) dose on 4/23/13 and 4/24/13, for agitation with no results noted. Review of the May 2013, MAR revealed R65 was administered Zyprexa 10 mg per day (2.5 mg above the recommended amount) and received the 5 mg PRN dose on 5/6/13 for agitation with	F 329		

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F 329	Continued From page 253 no results recorded. Review of the June 2013, MAR revealed R65 was administered Zyprexa 10 mg per day (2.5 mg above the recommended amount) and received the 5 mg PRN dose on 6/27/13 and 6/28/13 for agitation, no outcome noted for the medication. Review of the July 2013, MAR revealed R65 received Zyprexa 10 milligrams (mg) daily at 3:00 p.m. for a diagnosis of dementia and received six doses of PRN Zyprexa 5 mg between 10:30 p.m. and 12:00 a.m. for agitation. The target behaviors identified on the July 2013, Behavior/Intervention Monthly Flow Record included agitation, wandering in rooms and laying in others beds. The identified target behaviors were documented as not occurring on the night shift when the as needed Zyprexa was used. The interventions identified as used were redirect, one on one, give food and fluids and were noted as effective. R65 had been administered above the recommended amount of Zyprexa since admission of 1/22/13. The facility staff did not bring the Zyprexa 2.5 mg above the recommended amount to the physician's attention. The Behavior/Intervention Monthly Flow Records for 8/1 to 8/14/13, included target behaviors of agitation, wandering in rooms and aggressive behaviors for Zyprexa. The target behavior of agitation was documented as only occurring on the evening shift. The identified intervention for agitation was noted as offer food and fluids and was documented as effective. The target behavior of wandering in rooms was documented on the day and evening shifts as being continuous. The identified intervention on the day shift was noted as one on one and was noted as	F 329		

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not being effective with no other interventions identified as used. The intervention noted for wandering on the evening shift was redirect and one on one which was documented as being effective on all days documented. Aggressive behavior was noted almost daily on the evening shift with identified intervention of redirect which was noted as effective. The intervention of one on one was added on 8/15/13, during the survey and was noted as being effective.

A physician's order dated 8/14/13, directed to discontinue Zyprexa, start Tylenol (a mild analgesic) twice a day, and start Seroquel (an antipsychotic medication) twice a day and start Ativan every six hours as needed for anxiety/agitation.

Review of the Behavior/Intervention Monthly Flow Records started on 8/15/13, included target behaviors of wandering and agitation for Seroquel and physical aggression and physical outbursts for Ativan.

A Nurse's Notes dated 8/15/13, indicated R65 was directed away from another resident who was yelling and struck out at staff. R65 was given Ativan for increased agitation; there was no indication if R65 was agitated either before or after striking out at staff. On 8/17/13, R65 was noted to have been wandering from room to room, noted as agitated and was given Ativan.

When interviewed on 8/14/13, at 1:10 p.m. the director of nursing verified there had been no monthly orthostatic blood pressure monitoring for R65.

When interviewed on 8/19/13, at 9:56 a.m.

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F 329	Continued From page 255 registered nurse (RN)-A stated the only indications for use or Zyprexa were eating other resident's food, pacing, laying in other resident's beds and resistive to cares. A Pharmacy Recommendation/Communication Sheets Directions For Nurse Managers protocol dated 4/4/12, directed once the physician signed off with either a yes or no, to document in the nurses notes and put a note on the copy that the recommendation was complete. Review of the nurse's notes revealed there was no documentation or follow-up with the physician regarding the lack of response from the physician. R49's resident Admission Record dated 6/12/12, noted R49 had diagnoses of schizophrenia, anxiety, persistent mental disorder, and insomnia. R49's received psychotropic medications without adequate indications for the use of the medication. In addition, the facility did not establish appropriate target behavior monitoring and care planning for the use of the medication. On 8/19/13, at 9:56 a.m. R49 was observed in her wheelchair, wearing a shoe on the left foot and a sock on her right foot. She was carrying a stuffed animal horse. Calling out quietly "call the police, call the police." On 8/19/13, at 10:08 a.m. observed R49 to have the stuffed horse behind her in the wheelchair and was scooted forward and turned to the right side. Nursing assistant (NA)-J approached R49 to get her repositioned in the wheelchair and put the horse in her hands. R49 started yelling "AHHHHHH, GET ME MY MONEY, GET ME MY HOUSE, I AIN'T GOT NO MONEY." She continued to cry while NA-J stood next to her.	F 329		

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F 329	Continued From page 256 "GIVE ME MY MONEY." On 8/19/13, at 10:14 a.m. R49 observed bumping herself into a dining room chair, and trying to get "her baby" (the stuffed horse) settled in her lap. R49 then moved herself to the wall, and touched the fan (floor fan), picked up her right foot and grabbed the toes of her right foot "crying give me my shoes, give me my shoes." NA-J attempted to comfort her. - At 10:23 a.m. R49 had moved herself in a circle, but had calmed down. - At 10:32 a.m. R49 had moved the length of the dining room, approached a table with two other women and had not communicated with them. The care plan dated 6/25/12, indicated R49 had a lack of comprehension at times and was an elopement risk off of unit related to cognitive loss, confusion, vision loss, and hallucinations. R49 was received anti-psychotic medications and resisted cares. The MDS dated 6/14/13, indicated R49 was unable to complete the brief interview for mental status, required extensive assist of two for bed mobility and extensive assist of one for toileting, transfer, eating, dressing, personal hygiene, locomotion on and off unit and bathing. The medication orders were reviewed on 8/19/13, and indicated R49 received quetiapine (Seroquel) 50 mg po at bedtime for psychosis and quetiapine 25 mg three times a day for psychosis PRN, Ativan 1 mg po for anxiety and agitation, and zolpidem 5 mg (Ambien) at bedtime for insomnia as needed. The treatment record for August 2013 noted R49	F 329		

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F 329	Continued From page 257 had behavioral monitoring for anxiety, agitation, and delusions. The interventions for all three were to redirect and use 1:1. The behavioral monitoring treatment record was void of any documentation, and did not define what agitation or delusions looked like for R49. On 8/19/13, at 11:30 a.m. the DON and RN-A were interviewed regarding the target behavior sheets (delusions sheet with Seroquel labeled that did not match the delusion sheet for Ativan, both are up to date to today, but the number of delusions are recorded differently. The DON stated that the target behavior system needed to be revamped, the psychiatrist was being asked to address what behaviors the psychiatrist wanted observed and the facility was only going to address the medications that actually require target behavior monitoring. The SSD was working with the psychiatrist to develop a better system for the behavior sheets. The DON had also worked with pharmacy to develop a list that states what medications actually require target behavior sheets. The DON verified the target behavior flow sheets list anxiety as a target behavior but do not define what constituted anxiety behavior for R49. On 8/19/13, at 4:00 p.m. the consultant pharmacist verified the target behavior monitoring sheets were not individualized to specific resident behaviors, and a symptom of agitation or delusion needed to be defined for the individual behaviors the resident displayed. The consultant pharmacist verified duplicate target behavior sheets were not needed and having different documentation for the same stated target behavior (agitation or delusions) was confusing.	F 329		
F 387	483.40(c)(1)-(2) FREQUENCY & TIMELINESS	F 387		

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F 387 SS=D	Continued From page 258 OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 8 residents (R65) reviewed for unnecessary medications was seen by the physician once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter as required. Findings include: R65's medical was reviewed and it was noted R65 was only seen by the physician on 1/28/13, 5/3/13 and 8/6/13. The physician included on the Referral Forms dated 1/28/13 and 8/6/13, to have R65's next appointment in six months. The physician did not make face to face contact and the physician did not address the pharmacist recommendations of the use of the psychotropic medication. A psychiatry note dated 1/20/13, indicated R65 had severe dementia, potential delirium related to a urinary tract infection. The psychiatry note also indicated R65 received Zyprexa in the late afternoon related to a history of sun downing agitation, received as needed Zyprexa with little	F 387	**F387** 1. Corrective Action: A) Resident #65 was seen on 8/6/2013 by his physician. Since survey resident has been discharged from facility. 2. Corrective Action as it applies to other residents: A) All residents have the potential to be affected by the same deficient practice. B) The medical records of the current residents were reviewed for regulatory compliance with physician visits and any resident in need of a physician visit has either been seen in house or an appointment has been made for an out of facility face to face with their physician. C) Nursing and Medical Records staff have been educated on the physician visit requirement which reads: "The resident must be seen by a physician at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter".	

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F 387	Continued From page 259 effect, was noted to have been pacing around the unit and did not appear to be in distress. The Resident Admission Record indicated R65 dated 1/22/13, noted R65 to have diagnoses of dementia, alcohol abuse, depressive disorder, Alzheimer's disease, and history of brain injury. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 1/29/13, identified R65 as having had episodes of both physical and verbal aggression, wandered on the unit which included into other resident rooms. The admission Minimum Data Set (MDS) dated 2/4/13, indicated R65 had severely impaired cognitive skills for daily decision making, had physical/verbal and other behavior one to three days and wandered daily. The altered thought process care plan dated 2/11/13, identified R65 wandered without purpose and directed to allow for safe wandering in an uncluttered environment and re-approach if resistive. A Consultant Pharmacist's Medication Review dated 4/22/13, recommended review of the Zyprexa dose for R65 and indicated "when Zyprexa is used for behavioral management due to dementia-the recommended max Zyprexa dose is 7.5 mg/day [milligrams]." The physician signed the Consultant Pharmacist's Medication Review on 5/7/13, and did not include a response if the recommendation was accepted or rejected. Review of the Medication Regimen Review for R65 did not include any follow-up from the pharmacist regarding the lack of response from	F 387	3. Completion Date: 10/3/13 4. Recurrence will be prevented by: Random audits will be completed weekly x4 then monthly x3 with the findings being presented to the QA committee for follow up/planning. 5. Completion to be monitored by: Director of Nursing or Designee.	

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F 387	Continued From page 260 the physician regarding the Zyprexa recommendation written on 4/22/13. Review of the July 2013, MAR revealed R65 received Zyprexa 10 mg daily at 3:00 p.m. for a diagnosis of dementia and received six doses of as needed Zyprexa 5 mg between 10:30 p.m. and 12:00 a.m. for agitation. When interviewed on 8/15/13, at 10:42 a.m. social service designee (SSD)-A stated it had been difficult to have R65 see the current physician as required and because of the current insurance plan, R65 could not be seen by one of the facility physicians. No evidence was provided that the facility's medical director was consulted regarding R65's physician's visits. A policy and procedure was requested for physician's visits and none was provided.	F 387		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.	F 411	**F 411** 1. Corrective Action: A) Resident #82 has had dental services provided.	

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F 411	Continued From page 261 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services were provided for 1 of 2 residents (R82) reviewed for dental services. Findings include: R82 was admitted on 8/16/12, and Resident Admission record dated 8/16/12, noted the diagnoses to include but were not limited to diabetes mellitus, hypertension and dementia. During observation on 8/12/13, at 5:45 p.m. R82 was noted to have multiple broken teeth on the left upper side of her mouth and teeth that were black in color. The significant change in status Minimum Data Set (MDS) dated 7/5/13, identified R82 had no natural teeth or tooth fragment(s), required extensive assist of one for personal hygiene and was assessed to have severely impaired cognitive skills for daily decision making. The Care Area Assessment (CAA) for Dental Care dated 7/5/13, noted R82 had poor dentition with a history of refusing dental exams in the past and noted no referrals were needed. The Alteration in Dentition Care Plan dated 7/11/13, noted R82 had some missing teeth noted and a history of refusing dental exams. Approaches included, schedule dental exams as ordered/as she will allow- respect her right to decline.	F 411	2. Corrective Action as it applies to other residents: A) All residents have the potential to be affected by the same deficient practice. B) The facility has contracted with a new mobile dental company. C) Dental services will be offered routinely and on a PRN or emergency basis in accordance with regulatory guidelines. 3. Date of Completion: 10/3/13 4. Recurrence will be monitored by: Random audits will be conducted weekly x2 then monthly x3 with findings being presented to the QA committee for follow up discussion/planning.	

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F 411	Continued From page 262 Review of the Social Services Meeting/Assessment Updates of 9/5/12, 11/28/12, 2/20/13, 5/22/13, and 6/28/13, did not include information regarding dental services. Review of the medical record lacked any other evidence R82 was offered or was scheduled for a dental exam. The Social Services Meeting/Assessment Update dated 11/28/12, indicted R82 was unable to make decisions regarding her plan of care and the daughter would help make all decisions. The medical record lacked evidence R82's daughter was involved in decision making regarding dental care. When interviewed on 8/12/13, at 3:41 p.m. family member (F)-A reported R82's teeth problems slow her down a bit. Upon interview on 8/16/13, at 1:03 p.m. the director of nursing (DON) stated no dental visit information for R82 was available. The DON stated there had been issues with consent, transportation and scheduling for R82's dental care and R82 was scheduled for a dental visit on 8/23/13. A policy and procedure regarding dental care was requested and was not provided.	F 411	5. Completion will be monitored by: Director of Nursing or Designee	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general	F 425		

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F 425	Continued From page 263 supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure medications were available for 1 of 6 (R81) residents reviewed for unnecessary medications. Findings include: R81's psychotropic medication care plan 10/19/12, identified psychotropic drug use as R81 received a hypnotic and an anti-anxiety medication. The medications were not available for the staff to administer to R81. Review of R81's Hennepin County Medical Center Psychiatry clinic visit progress notes dated 6/17/13, indicated under assessment: "2. Insomnia. Patient reports her sleep is disrupted by the tremor. I am going to go ahead and try adding Ambien 5 mg at bedtime. 4. Severe anxiety. Currently Ativan she is getting at least t.i.d. [three times a day], which she needs to	F 425	**F 425** 1. Corrective Action: A) Resident #81 is receiving her medications as ordered and the physician was notified that the medications were missed on said dates. Her MAR/TAR and care plan was reviewed and revised as appropriate. 2. Corrective Actions at it applies to others: A) All residents have the potential to be affected by the same deficient practice. B) Nursing staff has been educated on the need to contact the pharmacy immediately if there is a medication ordered but not available to administer and that they must contact	

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F 425	Continued From page 264 control anxiety." R81's Physician Orders dated 6/17/13, directed zolpidem (Ambien-sleep aid) by mouth at bedtime. Another prescription dated 6/19/13, directed lorazepam (anti-anxiety) 1 milligram (mg) three times daily and another prescription R81's quarterly Minimum Data Set (MDS) dated 7/8/13, indicated R81 had anxiety disorder, delusions, manic depression and psychotic disorder (other than schizophrenia). MDS also indicated R81 was taking antipsychotic, antianxiety, antidepressant and hypnotic. During review of Medication Administration Records (MAR) dated 8/2/13 through 8/5/13, noted R81 had missed nine doses of Ativan and from 6/17/13 through 6/26/13, had missed 10 doses of Ambien also. During review of Nurse's Notes dated 6/17/13, through 8/5/13, at no point was the physician notified of medications not being available for resident. On 8/5/13, at 1:40 p.m. Nurse's Note indicated resident was noted to have increased tremors, sweating, droopy, had ate very little at breakfast, no lunch, had bad breath and the pharmacy had been called regarding Ativan and writer wrote had spoken with someone that medication had been sent out. On 8/15/13, at 10:21 a.m. consultant director of nursing (O)-D verified both medications had not been administered on those days and were circled with notes behind MAR for Ativan that "Ativan 1 mg not available nurse notified." O-D stated she was going to inquire from the pharmacy why medications supply was not	F 425	the physician if the pharmacy is not able to provide a prescribed medication. 3. Completion Date: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x4 then monthly x3 with the findings being presented to the QA committee for follow up discussion/planning . 5. Completion will be monitored by: Director of Nursing or Designee	

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F 425	Continued From page 265 available. On 8/15/13, at 10:23 a.m. registered nurse (RN)-A stated the pharmacy had issues with delivering medications in a timely manner to the facility. Licensed practical nurse (LPN)-A who was standing at the desk added that the pharmacy deliveries were being changed to twice daily with a late run to help solve the problem.	F 425		
	On 8/15/13, at 3:18 p.m. O-D approached this surveyor and stated that the pharmacy reported that medication was not filled as there was no script from the provider. Surveyor showed the O-D prescription script in the chart dated 6/17/13, that resident had brought to facility from appointment and had been noted on the same date. On 8/15/13, at 4:00 p.m. O-D stated she had called back to the pharmacy and had been told that the prescription script had not been received until 6/26/13, and medication was dispensed on 6/27/13. O-D and LPN-A provided a list of medications in the facility Pyxis machine (automated medication dispensing system) dated 8/15/13, on the list was Ativan and Ambien. Both agreed that staff should have gotten medications from the machine and given it to the resident until the pharmacy had supplied the medications. LPN-A also stated that Ativan was not stocked in the machine and that it had been stocked on 8/13/13. O-D stated that she was not aware that R81 had missed her medications and reported she had filled a facility medication error for both medications. On 8/16/13, at 9:38 a.m. RN-A stated her expectation was the trained medication aide's			

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F 425	Continued From page 266 needed to alert the nurse immediately to get medications from the Pyxis machine then call the pharmacy to "STAT" medication out to the facility. She also stated if the problem continued staff should let her know immediately to follow up. RN-A added, that the facility had discussed the issues surrounding supplying medications timely and had given the pharmacy thirty days to get it together. The pharmacy had also been instructed if there were issues with requiring or obtaining a script to contact the primary doctor immediately. On 8/16/13, at 12:45 p.m. the O-D stated her expectation was the TMA's needed to let the nurses know when the medications were missing and each resident needed to be given their medications as ordered. She added, if there was a problem with getting resident medications from the pharmacy, staff should let administration know of the issue. On 8/19/13, at 4:00 p.m. the consultant pharmacist supervisor covering for facility consultant pharmacist stated he, "Was not aware medications were not available at the facility for [R81], nursing should have communicated with the pharmacy regarding not having enough or no supply of medications for the resident on a timely manner, the facility should have taken the medications out of the Pyxis machine until the medication was supplied by the pharmacy. There should not have been a delay in starting resident's medications as ordered by the provider and in the case for resident missing medications for an extended period of time there was the potential to cause resident change in status if she was taking medication for anxiety but was not sure how resident was during the time she had not received medications." The consultant	F 425		

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F 425	Continued From page 267 pharmacist supervisor confirmed these medication were available in the Pyxis during the missed medication administration dates listed above. On 8/19/13, at 4:38 p.m. the facility consultant pharmacist stated, "Ativan and Ambien have always been in the Pyxis machine for the facility nurse to obtain if no supply and for controlled medications the nurse only needed to call the pharmacy to get a waiver to get the medications, there should not have been reason resident had missed medications as ordered and he was not aware of resident medication supply issues by pharmacy." The Psychotropic Drug Monitoring policy and procedure revised 3/7/97, identified that an, "Abrupt discontinuation of any psychotropic medication is strongly discouraged and dosage reductions should not occur more than once every month unless the attending physician feels special circumstances warrant quicker reductions."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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F 428	Continued From page 268 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 8 residents were free of unnecessary medications (R45, R35, R68). Findings include: R45 received Depakote (a seizure medication, also used as a mood stabilizing medication) without adequate indications for use. The facility and the consultant pharmacist did not establish appropriate target behavior monitoring and care planning for the use of the medication. A care plan dated 10/9/12, identified R45 was at risk for side effects from psychotropic drug use and identified R45 received "antidepressant med [medication]." The care plan did not include the use of Depakote. Doctor's Order Sheets indicated the following: - On 7/19/13, Depakote 125 milligrams (mg) by mouth (PO) twice daily (BID) was started for the diagnosis of anxiety; - On 7/30/13, the Depakote was increased to 250 mg PO BID for the diagnosis of anxiety. Review of the June, July and August 2013 Behavior/Intervention Monthly Flow Records indicated the following: - The June record identified target mood/behavior monitoring for Prozac and Remeron (antidepressants) was to be completed. Although the behavior sections of the sheets were blank, the evening shift had documented no behaviors. The day and night shift documentation was blank.	F 428	**F 428** 1. Corrective Action: A) Residents #45, 35 and 68 have had their medications reviewed by the consultant pharmacist and any recommendations were sent to the physician for review and response. B) Psychotropic Medications were reviewed and target behaviors and the indication for use of the medications were reviewed and revised. Updates were made to the care plan of Resident #45. C) Psychotropic Medications were reviewed and target behaviors and the indications for use of the medications were reviewed and revised. Updates were made to the care plan of Resident #35. D) Psychotropic Medications were reviewed and target behaviors and the indications for use of the medications were reviewed and revised. Updates were made to the care plan of Resident #68.	

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F 428	Continued From page 269 - The July record identified the target mood monitoring for Prozac was increased sadness and tearfulness. The target mood monitoring for Remeron was increased isolation. The clinical record lacked target behavior monitoring for the use of Depakote. - The August record included monitoring for Depakote was increased isolation, increased agitation/verbally abusive; target behavior monitoring for Remeron was "depression;" the target behavior monitoring for Prozac was increased sadness and increased tearfulness. The monitoring did not include resident specific target mood/behavior monitoring to determine indications for the use of the medications. The Monthly Medication Regimen Reviews indicated R45's medication regimen was last reviewed on 7/30/13. The review identified Remeron was increased to 15 mg. An undated side note indicated, "Depakote 125 Anx." On 8/19/13, at 3:35 p.m. the consultant pharmacist supervisor (CPS) stated anxiety alone would not be a strong indication for the use of Depakote. The consultant pharmacist stated monitoring for efficacy of the medication should be resident specific. CPS verified indications for use such and target behavior mood monitoring would be a part of the pharmacy review and should be identified as an irregularity. CPS stated the facility had a system problem which was facility wide and specific resident medication irregularities may not have been identified because it was a "bigger system problem." R35 lacked resident specific target mood/behavior monitoring to determine the	F 428	2. Corrective Action as it applies to other residents: A) All residents on psychotropic medications have the potential to be affected by this deficient practice. B) All residents with orders for psychotropic medications have had their medications reviewed by the pharmacist and recommendations were sent to the physicians for review and response. C) All residents who receive psychotropic medications have had their target behaviors and indications for use reviewed and revised. The changes are reflected on their care plans. D) Nursing staff has been educated on the importance of monitoring target behaviors and proper use of psychotropic medications. . 3. Completion Date: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be conducted weekly x4 then monthly x3 with findings	

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F 428	Continued From page 270 efficacy of Paxil, Trazodone and Wellbutrin SR (all antidepressant medications with different mechanisms) and the consultant pharmacist did not identify the concern. R35's Physician's Orders dated 7/28/13, directed to offer: - Paxil one 40 mg tablet PO daily for the diagnosis of "Depression." The Paxil was started on 12/20/12. - Trazodone half of a 50 mg tablet (25 mg) PO daily at bedtime for diagnosis of "Depression." The Trazodone was started on 12/20/12. - Wellbutrin SR one 200 mg tablet PO BID for diagnosis of "Depression." The Wellbutrin was started on 5/23/12. The care plan dated 3/15/10, indicated R35 was at risk for side effects from psychotropic drug use, such as hypotension (low blood pressure), movement disorder, gait disturbance (R35 was non ambulatory) and cognitive/behavior changes related to his diagnosis of "depression." The care plan identified the use of Paxil, Trazodone and Wellbutrin for "depression & Trazodone [sic] for Insomnia." The care plan identified, "His mood has been stable." An undated hand written update directed, "See Behavior/intervention monthly flow record for S/E [side effects]." The care plan identified goals of "no negative outcomes resulting from psychotropic medications" and "he will sleep at least 6 hours/night." The care plan directed: observe for med effectiveness and monitor for side effects; observe for drug related cognitive/behavioral impairment, such as delirium symptoms; observe for constipation, update the physician as needed, orthostatic blood pressures per facility protocol, observe for insomnia and difficulty sleeping;	F 428	presented to the QA committee for follow up discussion/planning. 5. Completion to be monitored by: Director of Nursing or Designee	

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F 428	Continued From page 271 provide a quiet, calm environment. Although the care plan identified the above, the care plan did not identify resident specific target mood indicators related to the use of Paxil and Wellbutrin slow release (SR). The Behavior/Intervention Monthly Flow Records for June, July, and August 2013 indicated the following: - The record for June directed licensed staff to monitor for "depression symptoms" with intervention of "Refer to S.W. [social worker]" for the use of Paxil. The month of June documentation was all "0's." Although a second monitoring record for Trazodone was blank for behaviors to be monitored for, "0's" were documented 13 times during the evening shift and twice on the night shift. The clinical record lacked evidence of behavior/mood monitoring for the use of Wellbutrin SR. - The record for July directed licensed staff to monitor for "Depression" with intervention of "Refer to S.W." for the use of Paxil. The month of July documentation was all "0's." Two more monitoring records for Trazodone and Wellbutrin SR were included with the monitoring, but were both blank. The clinical record lacked evidence R35 was monitored for sleep in July. - The record for August directed licensed staff to, "Document # [number of] hrs [hours of] sleep" for Trazodone. The documentation was of "0's" for the partial month of August and the number of hours R35 slept was not documented. Two monitoring records for Wellbutrin SR and Paxil directed licensed staff to monitor for "S/S [signs and symptoms of] Depression." The documentation was all "0's" for the partial month of August. The Behavior/Intervention Monthly Flow Records	F 428		

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F 428	Continued From page 272 lacked monitoring for resident specific depression symptoms, such as but not limited to irritable mood or refusal/rejection of care. The records indicated R35 was not consistently monitored for efficacy of Trazodone for sleep. In addition, the clinical record lacked evidence R35 was comprehensively assessed to determine monitoring for the concurrent use of two antidepressant medications (Wellbutrin SR and Paxil) which were both prescribed for the diagnosis of depression. The Monthly Medication Regimen Reviews indicated R35's drug regimen was last reviewed on 7/30/13, and the following: - On 10/18/12, "No GDR [gradual dose reduction] traz [Trazodone]" - On 1/18/13, Trazodone was identified as "not signed out." - A Consultant Pharmacist's Medication Review form dated 1/18/13, identified the three antidepressant ordered and identified the irregularity, "Patient continued to take above medications for 'depression'." and identified a need for a potential dosage reduction of "antidepressants." The note further communicated, "...particularly when more than one agent is being utilized to treat depression." The physician response dated 1/28/13, identified no dosage reductions were recommended and to refer R35 to psychiatry for reductions. Irregularities in monitoring for efficacy were not identified. - On 2/18/13, "traz" and "routine" was written down and, "Wellbutrin SR 200 BID + Paxil 40 + traz 25 HS [hour of sleep]" and further noted "address antidep [antidepressants] - DC [discontinue] traz." - A Consultant Pharmacist's Medication Review	F 428		

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F 428	Continued From page 273 form dated 2/19/13, identified the three antidepressant ordered and identified the irregularity, "Patient continued to take above medications for 'depression'." and identified a need for a potential dosage reduction of "antidepressants." The note further communicated, "...particularly when more than one agent is being utilized to treat depression." The physician response dated 2/21/13, identified no dosage reductions were recommended and to refer R35 to psychiatry for reductions. Irregularities in monitoring for efficacy were not identified. - On 7/30/13, "Repeat 4/13 Traz recom: [recommendation] since 12/2012." - A Consultant Pharmacist's Medication Review form dated 7/30/13, identified R35's use of Trazodone and, "This patient has been on his current dose of Trazodone since 12/20/12. It is appropriate to attempt a dose reduction every 3 months. Please consider changing this patient's Trazodone to a PRN [as needed]." The physician's response dated 8/1/13, directed to psychiatrist. Irregularities in monitoring for efficacy were not identified. On 8/19/13, at 3:35 p.m. the CPS stated the Paxil would be for a diagnosis of depression, but stated to monitor for "Depression" alone would not be appropriate. CPS stated he would expect to resident specific mood monitoring as outlined in the PHQ-9 and MDS. CPS verified indications for use such and target behavior/mood monitoring would be a part of the review and should have been identified as an irregularity. CPS stated the facility had a system problem which was facility wide. CPS explained he believed specific resident medication irregularities may not have been identified because it was a "bigger system	F 428		

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F 428	Continued From page 274 problem." R68 was on Effexor 75 mg at bedtime for depression since 5/17/12. R68's medication regimen irregularity, which had been identified by the consulting pharmacist on 4/22/13, had not been acted upon. A significant change Minimum Data Set (MDS) was completed on 7/19/13. The MDS noted the resident had long and short term memory issues and was considered moderately impaired. R68 did exhibit periods of being inattentive and disorganized thinking. He had no mood concerns or behavioral issues. The MDS indicated R68 was cooperative with staff efforts to provide him personal cares. Quarterly MDSs were completed on 3/22/13 and 6/21/13, and both assessments noted the resident had no problems with depression. The Care Area Assessment (CAA), completed on 7/12/13, noted the resident declined to participate in the assessment process. She indicated the resident did have disorganized thoughts and was inattentive. The CAA also noted R68's mood was stable and he was seen by the facility psychologist as needed. During the monthly medication review on 4/22/13, the consulting pharmacist questioned the need for a dose reduction of the antidepressant (Effexor). The pharmacist also noted on his pharmacy note of 5/28/13, of the antidepressant not being decreased. The pharmacist did not bring the information forward again to the director of nursing (DON) for the months June or July 2013.	F 428		

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F 428	Continued From page 275 A note, written by the facility nurse practitioner on 5/2/13, requesting the physician evaluate the resident's depression and trial dose reduction. Staff was instructed to review the medication with the resident's physician during his next visit but no later than two months. R68 was seen by his physician on 6/6/13 and 8/9/13, and evidence was not found of the physician reviewing the medication for appropriateness or considering a dose reduction. An interview with the DON on 8/19/13, at 12:16 p.m. was completed. She verified that physician should have reviewed the recommendations made by the pharmacist. An interview with a consultant pharmacist was done on 8/19/13, at 3:35 p.m. He reported the physician should have reviewed the recommendation. The undated facility's policy Medication Regimen Review (Monthly Report) specified the consultant pharmacist was to review the medication regimen of each resident at least monthly. The policy directed staff to ensure recommendations are acted upon and documented by the facility staff and/or the prescriber.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		

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F 431	Continued From page 276 reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 vial of Tubersol, used for tuberculin skin testing (TST), was not dated when opened. This had the potential to affect R99, R29, the director of nursing (DON), and future resident admissions and new employees. Findings include:	F 431	**F431** 1. Corrective Action: A) The expired bottle of Tuberculin solution has been discarded. 2. Corrective actions as it applies to other residents: A) All future residents and future staff members have the potential to be affected by the same deficient practice. B) Nursing staff was educated on the need to date Tuberculin solution when opened and to discard after 30 days. 3. Completion date: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be conducted weekly x4 then monthly x3 with findings presented to the QA committee for follow up/discussion.	

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F 431	Continued From page 277 On 8/14/13, at 11:45 a.m. trained medication aide (TMA)-F referenced a list taped to the top of the medication cart which provided direction to staff passing medications, as to when a particular medication was to be removed from the medication cart after opening. On 8/14/13, at approximately 11:50 a.m. a vial of Tubersol was found opened in the third floor locked medication room refrigerator. The vial was not dated when opened. The open and undated Tubersol vial was verified by licensed practical nurse (LPN)-I. A review of immunization records revealed R99 and R29 received 0.1 milliliters (ml) of Tubersol on 5/1/13; and two staff, received 0.1 ml. The DON received a dose on 8/9/13, and nursing assistant (NA)-Z received 0.1 ml on 5/15/13. The February 2013 package insert for vial of Tubersol noted the vial was only good for 30 days when opened and the package insert stated "Do not use after expiration date."	F 431	5. Completion will be monitored by: Director of Nursing or Designee	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure kitchen equipment (dishwasher) was maintained in a	F 465	F 465 1. Corrective Action: A) The inside and outside of the dishwasher has been cleaned and a cleaning schedule is in place.	

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F 465	Continued From page 278 clean manner free from debris which could potentially contaminate clean dishes. This had the potential to affect 62 of 66 residents that ate in the facility; the facility failed to provide a clean dining area on 1 of 3 dining areas in the facility which had the potential to affect 15 of 17 residents (R33, R56, R82, R87, R26, R49, R65, R38, R37, R53, R81, R32, R40, R70, R72) who ate in the dining room; and the facility failed to ensure resident care equipment was maintained in a clean and functional condition for 3 of 4 residents (R45, R1, R35). Findings include: Findings include: Dishwasher: On 8/12/13, at 12:13 p.m. during the initial sanitation kitchen tour with the director of dietary (O)-F surveyor observed yellowish, greenish and whitish colored substance along the seams and edges of both the mid-top and inside side sections of the dishwasher. The substance appeared to be thick, porous and loose; it flaked away easily with a fingernail. Also observed a plate screwed to the wall on the right side of the inside side of dish washer covered with thick brownish substance. O-F verified the yellowish, greenish and whitish colored substance on the seams and edges of dishwasher was lime. Additionally, the brownish buildup substance on the plate was rust which was all buildup on the inside side of the dishwasher. On 8/12/13, at 12:15 p.m. O-F stated the inside of the machine was de-limed every two weeks by staff, the staff cleaned the outside daily and the facility maintenence staff was responsible to	F 465	B) The dining room tables on each floor were cleaned immediately and are being cleaned routinely after each meal to assure sanitary eating conditions for the residents at St. Olaf's. C) The quad cane and w/c of resident #45 were cleaned immediately and staff are monitoring routinely for the need to clean the devices when soiled. D) The electric w/c of resident #1 was cleaned immediately and staff are monitoring routinely for the need to clean it when it appears soiled. E) Resident #35 has received a new mattress.	

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F 465	Continued From page 279 clean the outside of the dishwasher if the dietary staff was not able to clean it. O-F verified the facility had no outside contractor who performed routine professional cleaning except for checking to make sure the dishwasher was properly working in regards to water temperatures and operation of the dishwasher. O-F stated the lime could potentially contaminate the cleaned dishes. The facility Cleaning Schedule dated 4/6/13 through 8/31/13, directed staff to de-lime the inside of the dishwasher weekly but lacked direction to address de-liming the outside surfaces, seams, edges and adjacent areas of the clean side of the machine. The Kitchen Report dated 7/24/13, servicing listing provided by Hillyard (manufacturer and distributor of janitorial products, sanitary supplies and equipment) only indicated the services performed as, "Tested chemical system, working good. Test ran dish machine, working good." The undated Equipment Operations, Infection Control & Sanitation policy indicated, "The Dietary staff shall maintain the sanitation of the Dietary Department through compliance with written, comprehensive cleaning schedules developed for the facility by the Dietary Manager. The procedure directed, "SANITATION OF EQUIPMENT. Frequency: After each meal 4. Wipe exterior of machine and soap dispenser. Dry and polish with cloth. Frequency: Weekly Clean dishmachine exterior with deliming solution." Although the policy and procedure directed a pertinent cleaning routine, the policy lacked direction to report cleaning, maintenance and who was responsible to address all the needs of the dishwasher to ensure dishwasher	F 465	2. Corrective Action as is applies to other residents: A) All residents who eat their meals at St. Olaf's have the potential to be affected by this deficient practice. B) The housekeeping staff was educated on the need to wash tables after meals. The nursing staff was educated on the need to wash the dining room tables in the absence of housekeeping staff. C) A dishwasher cleaning/de-liming schedule has been put into place to assure that both the interior and exterior of the dishwasher are clean.	

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F 465	Continued From page 281 R45's quad cane and wheelchair (W/C) were observed to be soiled with food spills and spatters on 8/12/13, and on 8/14/13. On 8/12/13, at approximately 6:36 p.m. R45's quad cane was observed to have a buildup of oily debris on the base of the cane, the W/C was observed to have many food spatters and spills on both sides of the W/C frame and both wheels. During random observations from 8/12/13, through 8/14/13, the following was observed: -On 8/14/13, at approximately 8:00 a.m. R45 was observed to be wheeling past the nursing station to go to the elevator. The W/C was observed to have oily food spatters on both sides of the W/C frame. On 8/15/13, at approximately 3:00 p.m. the registered nurse manager (RN)-A confirmed the coffee cup, the W/C and quad cane were soiled (as indicated above). RN-A confirmed the equipment should have been cleaned. RN-A stated she did not know about the soiled coffee cup and confirmed staff should have identified the need to clean the items. RN-A stated W/Cs were usually cleaned on the night shift, but was unclear when R45's W/C was last cleaned. 8/16/13, at 2:57 p.m. during the environmental tour the O-C confirmed the W/C was dirty and had food splatters on the wheels and frame. O-C stated the W/Cs are cleaned once monthly on Tuesdays according to floors, but could be cleaned twice a month if it had been reported to the maintenance department. R1's electric W/C was observed to be heavily soiled with whitish, and browish multiple food	F 465	Director, Dietary Manager or their Designee's See Addendum Completion date of 10/3/2013 Attached	

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F 465	Continued From page 282 spills on the W/C frame from 8/13/13, at 1:48 p.m. through 8/16/13, at 3:02 p.m. when the administrator and the environmental service director (O)-C verified it was food spills and spatters. On 8/16/13, at 3:05 p.m. during facility environmental tour the O-C stated electric W/Cs were only deep cleaned once a month by the facility and nursing was responsible to wipe down the W/C every evening if staff noted it was soiled with food debris. The W/C cleaning log and schedule was requested but was not provided. The W/C Cleaning policy revised 12/1/11, directed "To provide residents with safe and sanitary wheelchairs. All wheelchairs are to be checked and cleaned on a monthly basis. Nursing department will be responsible for daily spot cleaning of wheelchairs." The W/C cleaning log and schedule was requested but was not provided. R35's mattress was observed to be ripped on the right side of the mattress. The ripped mattress was not reported for replacement. On 8/14/13, at 7:53 a.m. R35 was observed to be transferred from the bed to the W/C. The outer cover of R35's mattress was observed to be ripped the entire length of the right side of the mattress. The foam of the mattress was exposed. At 9:27 a.m. R35 was transferred back into bed. The bed was made prior to the transfer by nursing assistant (NA)-A. The sheets were made over the ripped mattress. At 9:35 a.m. the NA-H	F 465		

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F 465	Continued From page 283 and NA-A verified the mattress was ripped and stated the rip was "not new." Both NA staff stated the mattress had been ripped for a "month" and stated the mattress had been reported. NA-H stated items in need of repair were documented in a book at the nursing station. During review of the Environmental Services Requisitions Communication Log Maintenance, Housekeeping and Laundry book there was no report/request written that R35's mattress was ripped. On 8/14/13, at10:06 a.m. the administrator stated he overheard the surveyor asking about the mattress and he was going to check the same book to see if it was reported. The administrator confirmed R35's ripped mattress was not logged in the log book. The administrator stated the mattress would need to be special ordered. The administrator verified R35's mattress cover had "deteriorated" and the mattress would need to be replaced. The administrator stated book was the way maintenance staff was notified of repair requests and needs. The facility's Environmental Functioning and Cleanliness policy and procedure dated 12/1/08, indicated, "St Olaf Residence Inc. Staff are responsible to operate and maintain the building so as to provide the occupants with a comfortable, safe and functional environment suitable for the provision of care; and maximize the longevity of the building, fixtures and equipment." The policy directed, "Appropriate practice if cleaning and repair should include visual observations, equipment function testing and inspection for abnomal conditions." The "Commitments:" section of the form directed, "1.	F 465		

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F 465	Continued From page 280 was maintained in a clean manner free from debris which could potentially contaminate clean dishes. Dining room tables: The second floor dining room tables were observed to not be clean 8/12/13, 8/13/13, 8/14/13, 8/15/13 and 8/16/13. On 8/12/13 through 8/16/13, the four tables in the main second floor dining room area were observed to have browish, spatters and sticky substance on the edges, metal area space beween the table tops and the pedestal and the pedestals itself of all the tables. The observations were mid afternoon to evening on 8/12/13, on 8/13/13 through 8/16/13, mid morning and early evening. During that week housekeeping staff were observed on several occurances cleaning the area after meals which included wiping the tables, however, staff never cleaned off the sticky, browishish food spatters on the tables and attached surfaces. On 8/16/13, at 2:43 p.m. during facility tour the environmental service director (O)-C and the administrator verified the four tables were not clean as the browish, sticky substance was dust and food spatters remained on all the tables and attached areas. O-C further stated the tables were not on a routine cleaning schedule but he expected the tables to be cleaned on a daily basis by housekeeping staff as they do regular routine in the unit to maintain a clean area.	F 465		

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 465	Continued From page 284 Keeping St Olaf Residence clean is everyone's responsibility." and "4. Building and equipment repair and/or replacement shall be completed as needed."	F 465		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain a waiver to modify the toilet room in a resident room (R7) who utilized a sliding board for transfers. Findings include: R7's sleeping area was observed to have an unenclosed toilet and sink that resident was using. The enclosed water closet was void of a toilet and sink. MN Rule 4658.4005 APPROVAL OF PLANS; NEW CONSTRUCTION noted "Preliminary plans and final working drawings and specifications for proposed construction must be submitted to the commissioner of health for review and approval. Preliminary plans must be approved before the preparation of final working drawings is undertaken. Final working drawings and specifications must be approved before	F 492		

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F 492	Continued From page 285 construction is begun." R7's diagnoses included left above the knee amputation and morbid obesity per Minimum Data Set (MDS) dated 5/21/13. Additionally, the same MDS identified R7 required extensive physical assistance of two for transferring functional ability and one physical extensive assist with toileting. On 8/12/13, at 4:30 p.m. surveyor observed the toilet in resident sleeping area to the right when entering room with sink next to it, and bed located on the opposite left side of the room. Resident stated that the facility had made the modifications and had sure helped him to continue being continent and independent with toileting. He showed surveyor a binder with instructions of how he transferred to the toilet using a sliding board. On 8/16/13, at 2:15 p.m. during the facility tour with the administrator and environmental service director (O)-C, the administrator stated "the toilet and room modification work had been started in March 2013 and completed end of April 2013", and was not sure of the specific dates when the work was completed. O-C stated that during the modifications "the plumber came in and relocated the sink and toilet pipes and did the connection on the ceiling piping on the floor below." O-C further stated the hole in the bathroom where the toilet had been moved from was sealed. Both the administrator and O-C stated the facility had no waiver per regulations for room modification and putting toilet in resident sleeping area nor was the comissioner of health notified of the re-construction.	F 492	F492 Corrective Action: A waiver has been requested for the toilet in the room of Resident # 7 and the Commissioner of Health has been notified of the re-construction upon change of resident room. Corrective Action as it applies to other residents: Waivers will be applied for and the Commissioner of Health will be notified of any future construction or revision to resident's rooms. Therapy has screened to assess other toileting options. Date of Completion: 10/3/13 Recurrence will be prevented by: Random room audits will be conducted monthly with new findings reported to the QA committee for follow up discussion/planning. Completion will be monitored by: Administrator	
F 497	483.75(e)(8) NURSE AIDE PERFORM	F 497		

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F 497 SS=F	Continued From page 286 REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure performance reviews were completed annually for all of the employees in the facility. This had the ability to affect all 66 residents in the facility. Findings include: Nursing assistant (NA)-A was hired 8/6/01, the last performance evaluation was 10/28/09. NA-B was hired 11/6/2000, the last performance evaluation was 4/20/09. NA-C was hried 6/12/2000, the last performance evaluation was 9/8/09. NA-D was hired 8/1/94, the last performance evaluation was 11/17/09. NA-E was hired 8/23/93, the last performance evaluation was 11/19/09. NA-S was hired on 5/14/08, and has had no	F 497	F 497 1. Corrective Action: A) The Performance Evaluations of all Nursing Assistants have been completed and the Performance Evaluations of all other facility staff are also being completed. B) On-going education is being provided to NAR's to meet the 12 hour annual requirement. 2. Corrective Action as it applies to others: A) All staff has the potential to be affected by the deficient practice. B) Department Heads and Nurse Managers have been educated on the need to complete annual performance evaluations on their staff. C) Regularly scheduled in-service education will be provided in accordance with regulatory requirements. 3. Date of completion: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x4 then	

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F 497	Continued From page 287 performance evaluations since 6/9/10. NA-T was hired on 7/1/08, and has had no performance evaluations in the employee file. NA-U was hired 4/8/12, and had no current performance evaluations in the employee file. NA-V was hired 12/1/11, and had no current performance evaluations in the employee file. An interview with human resources on 8/15/13, at 11:30 a.m. verified there was no evidence of performance evaluations for NA-A, NA-B, NA-C, NA-D, NA-E, NA-S, NA-T, NA-V were located in the employee's file.	F 497	monthly x3 with findings presented to the QA committee for follow up discussion and planning. 5. Completion will be monitored by: Administrator and/or Director of Nursing or their Designee	
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure medical records were complete and accurately orderly for 11 of 20 residents (R15, R42, R601, R41, R35, R68, R1, R65, R23, R12, R48). This practice had the	F 514	F514 1. Corrective Action: A) The Medical Records of Residents #15, 42, 601, 41, 35, 68, 1, 65, 23, 12 and 48 have been reviewed for accuracy and put into the proper order. The facility has assured that filing is accurate and contains only the resident's record for which the Medical Record is meant.	

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F 514	Continued From page 288 potential to affect all 66 of 66 residents residing in the facility. Findings include: R84's medical record was reviewed on 8/12/13, at 4:47 p.m. In the medical record for R84 were medical documents for R15, R42, and R601. Registered nurse (RN)-C was given the misfiled documents, RN-C stated the documents should be filed in the correct charts, and verified that misfiled documents could lead to medical errors. RN-C further stated that most of the filing was done by the health unit coordinators (HUC) and that the nurses do help file when time permits. R41's medical record information was incorrectly filed in R35's medical record. On 8/19/13, at 10:52 a.m. after copies of R35's medical record were flagged and requested, the consultant RN was observed to provide a copy of R41's Consultant Pharmacist Medication Review form dated 8/12/13, from R35's medical record. The consultant RN verified the R41's review was filed incorrectly in R35's medical record. The consultant RN verified the form should have been filed in R41's medical record. R68's medical record was reviewed on 8/15/13, at 3:50 p.m. A Physician's Order for R68 was found in the medical record of R1. Also, noted in R1's medical record were two dental forms for R65. The licensed practical nurse (LPN)-G was notified and orders and forms were removed from R1's medical record. R23's Physician Orders were reviewed on 8/16/13. During the review it was noted that R12's	F 514	2. Corrective Action as it applies to other residents: A) The Medical Records of all residents are being reviewed for chart order and accuracy. B) Medical Records will be filed in the proper charts and under the appropriate chart tabs. C) The Medical Records chart order has been disseminated on the floors. Staff are also to double check proper placement in the correct Medical Records. 3. Completion Date: 10/3/13 4. Recurrence will be prevented by: A) Random audits will be completed weekly x4 then monthly x3 with findings being presented to the QA committee for follow up discussion/planning. 5. Completion will be monitored by: Director of Nursing or Designee	

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F 514	Continued From page 289 and R48's signed Physician Orders for July 2013 were both filed between R23's May and June 2013 Physician Orders. On 8/19/13, at 10:00 a.m. after requesting several copies from R23's permanent chart, copies of R12's and R48's signed Physician Orders for July 2013 were provided by consultant director of nursing (O)-D. At the time RN-A and O-D both verified R12's and R48's original Physician Orders and copies provided were filed in the wrong chart R23's. On 8/19/13, at 10:15 a.m. interviewed O-D and RN-A standing by at the time stated the medical records staff or health unit coordinator were responsible with filing but added at times nurses filed various forms in the charts. On 8/19/13, at 5:34 p.m. the administrator and director of nursing (DON) were interviewed regarding quality issues identified during the survey. The DON confirmed there were medical record issues of documents filed in the wrong charts and orders that had not been implemented. The undated Medical Records Filing Procedure directed "1. Upon admission, a medical record file will be created for each resident. The medical record number will be indicated using..... The medical record files are filed by order of the medical record number. 2. During the resident's stay, the medical record file will contain a copy of the completed Identification and Summary, as well as any correspondence (releases, authorizations, etc.) created during the resident's stay. "The policy lacked who was responsible to oversee that the residents medical	F 514		

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F 514	Continued From page 290 records were kept accurate.	F 514		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Quality Assessment and Assurance committee (QAA) identified and assessed quality concerns related to the development/review/revision of the facility's elopement policy and failed to ensure the	F 520	F520 1. Corrective Action: A) Elopements and the Wander Guard system review will be a part of the QA meetings until further notice. B) Medical Records policy and procedures will be reviewed at QA meetings until further notice. C) Medication Delivery and Medication Administration will be reviewed at QA meetings until further notice. D) The Medical Director and Board of Administrators have been notified of the IJ situation in the facility. E) Incidents and Accidents will be a routine part of the QA meeting. F) All areas identified on the 2567 will be monitored through the QA process until further notice.	

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F 520	Continued From page 291 Wanderguard (departure alert system) was functional to prevent elopement for 1 of 6 residents (R45). In addition, the facility did not development/review/revision the facility's policies and procedures regarding medical records and medications. This had the ability to affect all 66 residents in the facility. Findings include: Elopement: R45 had successfully eloped from the facility five times in the month of July on 7/1/13, 7/2/13, 7/11/13, 7/29/13, and again on 7/31/13 per the clinical record. The clinical record lacked evidence R45's Wanderguard was consistently monitored for placement and function; the nursing staff did not know where R45's Wanderguard was placed on his wheelchair (w/c); the facility lacked the equipment to check R45's Wanderguard for function. Although staff accompanied R45 on scheduled walks outside the facility twice daily at 10:00 a.m. and 2:30 p.m. to reduce attempts to leave the facility, the facility lacked a functional Wanderguard system to potentially prevent R45's elopements from the facility R45's signed Patient Medical Care Plan (Physician's Orders) dated 11/15/12, through 7/31/13, all directed, "Wanderguard check placement & function every shift." A Telephone order dated 7/2/13, at 8:00 a.m. indicated, "OK for Wanderguard." R45's care plan dated 9/27/13, identified, "Resident at risk for harm from self or others R/T [related to]: 1. Dx [diagnosis] of depression 2. Dx of CVA [cerebral vascular accident, stroke] 3. Dx of persistent mental disorder... AEB [as	F 520	2. Corrective Actions as it applies to other residents: A) Elopements and the Wander Guard system review will be a part of the QA meetings until further notice. B) Medical Records policy and procedures will be reviewed at QA meetings until further notice. C) Medication Delivery and Medication Administration will be reviewed at QA meetings until further notice. D) The Medical Director and Board of Administrators have been notified of the IJ situation in the facility. E) Incidents and Accidents will be a routine part of the QA meeting. F) All areas identified on the 2567 will be monitored through the QA process until further notice. G) The Quality Assurance Policy has been reviewed and staff members were educated on the process. 3. Completion Date: 10/3/13 4. Recurrence will be prevented by: 5. Completion will be monitored by: Administrator or Designee	

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F 520	Continued From page 292 evidenced by]: 1. Resdient [sic] has a history of making suicidal statements/actions." The care plan dated 10/9/12, identified R45 had, "Impaired Communication r/t impaired cognition, dementia - persistent mental d/o [disorder]...ability to make self understood & understand others is impaired." A hand written care plan for falls dated 10/21/12, identified R45 had potential for fall r/t weakness and left hemiplegia (paralysis on the left side). The care plan dated 7/31/13, indicated, "Resident prefers activities that identify with prior lifestyle i.e. [in example] walking program" and identified R45 would "have staff walk him at 10 AM and 2:30 PM. If he is compliant with sticking to these times resdient [sic] will get a treat of his choosing. Resdient [sic] to sign a walking program contract agreeing to above." The interventions further directed, "OT [occupational therapy] to work with resdient [sic] (modified community integration with behavior mod [modification])." A hand written update dated 7/13 indicated, "1. Wanderguard applied [crossed out] initiated - check placement/function per protocol. 2. Post photograph of resident at appropriate place 3. Allow safe mobility in uncluttered environment 4. Encourage movement & exercise in environment 5. Redirect & reorient in gentle manner 6. Offer calm reassurance, 7. Reproach if resistive 8. Cont [continue] walks outside w/ [with] staff 1-2 x day weather permitting." In addition, the care plan identified R45 could be physically and verbally abusive; he resisted care, made negative statements, and he had a history of "attempting to choke self with hand." Although the care plan identified R45 had a Wanderguard. The care plan did not identify R45's elopement risk, elopements from the facility or attempts to enter unsafe areas of the facility, such as the stairwell. The care plan lacked interventions to address prevention of	F 520		

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F 520	Continued From page 293	F 520		

elopement, such as placement of the Wanderguard, R45's history of attempts to remove the Wanderguard, reasons for the Wanderguard, nursing interventions to address elopement attempts. Although the care plan identified a "walking program" for R45, the care plan did not identify if R45 was supposed to walk with a cane or to be escorted while R45 used a wheelchair. The care plan lacked safety consideration related to elopements, such as safety assessment schedules or R45 refusing to allow the wheelchair to be touched while out on the walking program.

On 8/16/13, at 1:45 p.m. the DON was interviewed regarding elopements, and stated she believed an elopement was reportable to the State agency when a resident left the "facility property." The DON stated that was why the elopements were not reported to the State agency. The DON stated she believed since the receptionist saw R45 leave the facility, had called for assistance and R45 was in visual sight, it was not considered an elopement. The DON confirmed the elopements occurred prior to her employment to the facility; verified the sidewalk around the facility, the parking lot and pavement was uneven and unsafe. The DON verified she had walked with R45 outside the facility and R45 would not always allow her or staff to touch the wheelchair. The DON verified R45 was able to move fast when wheeling the wheelchair outside the facility.

On 8/16/13, at 3:58 p.m. registered nurse (RN)-A stated checking for Wanderguard placement and function could be "delegated" to nursing assistant (NA) staff, but the nurse documented the results. RN-A stated she remained unclear if or when the

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F 520	Continued From page 294 Wanderguard was removed in July 2013, but stated she thought the Wanderguard was first applied to R45 on 11/2012. On 8/19/13, at 10:05 a.m. the occupational therapist verified R45 was in therapy for "community involvement." Occupational therapist stated the treatment was to develop approaches with R45 while he was out on walks in the community. Occupational therapist stated R45 did not want staff to be with him and the nursing staff was "confused" on behavioral approaches with R45. The occupational therapist stated therapy staff provided teaching on how to talk to R45. The occupational therapist stated she went out with R45 on the walks, timed them and explained to R45 why staff was with him; encouraged R45 to choose times and for staff to not make R45 feel "isolated" as he was being escorted on these walks. The occupational therapist denied the therapy was to "prevent" potential elopements and stated the therapy was to assist with compliance with the walks around the block twice daily. On 8/19/13, at 5:34 p.m. the administrator stated elopements came up in QA as part of the incident review (not as an identified problem). The administrator verified environmental and safety concerns such as door/Wanderguard testing was not a part of QA, but will be a new part of QA. The Elopement Assessment policy and procedure dated as revised on 5/15/13, identified the facility policy was to assess each resident to identify potential risk factors for elopement. The policy identified, "All residents will be assessed on admission and annually for elopement. That resident determined to be 'at risk' for elopement	F 520		

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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 520	Continued From page 295 will be assessed quarterly." The policy directed the completion of the "Elopement Risk Assessment [Risk of Elopement/Wandering Review]." The policy further directed to apply appropriate interventions from the "list" at the bottom of the form, directed to complete an "elopement prevention/management care plan." The policy further directed, "8. If Wanderguard is an intervention. Test Wanderguard to ensure it [sic] working properly before putting on resident. 9. Implement signaling device testing calendar, test Wanderguard daily and sign daily that it is tested and working." The undated Wanderguard Departure Alert System manual directed to use a "Universal tester" within one foot of the Wanderguard bracelet, press and release the bracelet button one time, the tester light will blink green four times if the bracelet was active and has tested as "good." The manual also included directions to test the Wanderguard at the door to determine function. The manual further directed to keep the Wanderguard away from metal jewelry if applied on a resident, or away from metal when affixing it to a wheelchair. The manual directed to mount the Wanderguard on the back of the wheelchair and not against the metal frame and indicated the metal may "interfere" with the Wanderguard function. R45's Wanderguard was placed at the metal crossbars of the wheelchair. Medical records and medications: On 8/19/13, at 5:34 p.m. the administrator and director of nursing (DON) were interviewed regarding quality issues identified during the survey. The administrator confirmed he had attended a	F 520		

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	245387	A. BUILDING _____ B. WING _____	C 08/19/2013

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F 520	Continued From page 296 Quality (QA) meeting in the facility. He stated the facility identified concerns through audits. The audits were then reported and discussed through the QA meeting. The facility had completed a "mock survey" to identify pieces which needed to be "fixed or addressed." The DON confirmed there were medical record issues of documents filed in the wrong charts, orders that had not implemented, and problems and medications not being provided even though they were available in the Pyxis (electronic medication kit). The mock survey information was provided to the governing board. The administrator stated he had educated the governing board on the time factors with compliance from the quality team reports. It was unclear if the governing board was notified of the immediate jeopardy (IJ), but stated he expected the medical director to be notified. The DON notified the clinical director of the medical director's (MD's) clinic, and she would pass on the information. The DON stated the MD, wanted to see quality data, and did review the trending and tracking of falls in the past, and analysis of the trending by shift, location. The administrator stated the facility was currently working on grievance responses, and data from satisfaction survey, and doing root cause with customer complaints. Ongoing quality projects were the mock survey, and continuing to improve that, tightening up the admission process, making sure orders are followed up on, ensuring plans are put in place, streamlining policy and procedure. The administrator also wanted to tighten up the	F 520		

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F 520	Continued From page 297 Minimum Data Set (MDS) using the Care Area Assessments (CAAs) to develop better care plans. Pull the medical record job descriptions to streamline that piece, especially with orders. A new communication board had been implemented. The administrator wanted to encourage the health unit coordinators to be a resource. A nursing assessment book was implemented by the DON. A new 24 hour sheet had been implemented. The facility planned to implement a new way to do admissions with pharmacy, such as getting consents right away, improving new sleep study forms, adding orthostatic blood pressure checks for psychotropic medications. The administrator stated since the DON had been hired, roles were defined better, and incidents were being examined.	F 520		

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F 465	Continued From page 280 was maintained in a clean manner free from debris which could potentially contaminate clean dishes. Dining room tables: The second floor dining room tables were observed to not be clean 8/12/13, 8/13/13, 8/14/13, 8/15/13 and 8/16/13. On 8/12/13 through 8/16/13, the four tables in the main second floor dining room area were observed to have browish, spatters and sticky substance on the edges, metal area space beween the table tops and the pedestal and the pedestals itself of all the tables. The observations were mid afternoon to evening on 8/12/13, on 8/13/13 through 8/16/13, mid morning and early evening. During that week housekeeping staff were observed on several occurances cleaning the area after meals which included wiping the tables, however, staff never cleaned off the sticky, browishish food spatters on the tables and attached surfaces. On 8/16/13, at 2:43 p.m. during facility tour the environmental service director (O)-C and the administrator verified the four tables were not clean as the browish, sticky substance was dust and food spatters remained on all the tables and attached areas. O-C further stated the tables were not on a routine cleaning schedule but he expected the tables to be cleaned on a daily basis by housekeeping staff as they do regular routine in the unit to maintain a clean area.	F 465	D) All Resident mattresses were checked for rips and deterioration and replaced as necessary. E) A w/c and assistive device cleaning schedule was put into place. The cleaning of the w/c's and assistive devices will be logged routinely. 3. Completion date: 10/3/13 4. Recurrence will be prevented by: A) Random weekly audits will be completed weekly x4 then monthly x3 with findings being presented to the QA committee for follow up discussion/planning . 5. Completion will be monitored by: Director of Nursing, Maintenance	

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F 309	Continued From page 129	F 309		

aware of the resident not being weighed before and after dialysis. She also reported all weight obtained would be documented in the medical record.

The Physician Orders, signed on 8/1/13, directed staff to measure R68's blood pressure before and after dialysis. A review of the medical record revealed in June, 2013-blood pressure was taken as ordered on two days (6/1/13 and 6/6/13) and not taken as ordered 53% of the time. During July, 2013-the resident's blood pressure was taken as ordered on four days (7/6/13, 7/16/13, 7/20/13 & 7/30/13) but not taken as ordered 50% of the time. During August 1-13, 2013- the resident's blood pressure was taken as ordered four times (8/3/13, 8/8/13, 8/10/13 & 8/13/13) and no taken as ordered 25% of the time.

An interview was completed with LPN-D on 8/14/13, at 2:25 p.m. She reported she was not aware that the resident's blood pressure was not being taken before and after dialysis as ordered by the physician. She reported all blood pressures taken would be charted in the medical record.

An interview on 8/14/13, at 1:20 p.m. with the dialysis program registered nurse (DPRN). He reported the staff at the dialysis program contacted the facility and informed them on 6/22/13, the resident's potassium level was critically high and as result, he was seen at a local emergency room for evaluation. A review of the medical record noted on 6/27/13, the facility physician ordered staff to administer Kionex suspension (a medication used to treat elevated potassium levels) 15 grams by mouth every day. Since that order was written, the resident had

I) The facility has contracted with a new mobile Dental service to meet the needs of residents who cannot go out to dental appointments.

3. Date of Completion: 10/3/13

4. Recurrence will be prevented by:
A) Random audits will be completed weekly x 4 and then monthly X3 with results being presented to the QA committee for follow up discussion/planning.

5. The Correction will be monitored by:
The Director of Nursing or Designee

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	245387	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/13/2013

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K 000	INITIAL COMMENTS	K 000		

POC ok
11-12-13

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE SED AS VERIFICATION OF COMPLIANCE.

DC: 9-18-13

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, St Olaf Residence was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 482.41 (b), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety Code" (LSC), Chapter 19 Existing Health Care.

EXIT: 8-19-13

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

RECEIVED
NOV 12 2013
DEPT OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 9/25/13

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 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficienc . 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. St Olaf Residence is a 4-story building with a basement. The original building was constructed in 1964, is separated from a church with a 2 hour fire rated barrier and was determined to be of Type I (332) construction. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection throughout the corridor system, in common areas and areas open to the corridor system and is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 66 at the time of the survey. The requirement at 42 CFR, Subpart 482.41 (b), is NOT MET as evidenced by:	K 000		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. · Non-rated protective plates that do not exceed 48 inches	K 027		

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K 027	Continued From page 2 from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect all residents. Findings include: On facility tour between between 10:00 AM and 12:30 PM on 08/13/2013, observation revealed that the door sequencer for the third floor smoke barrier doors failed to properly function. This deficient practice was verified by the administrator at the time of the inspection.	K 027	**K 027** Corrective Action: 1) The door sequencer was replaced for the third floor smoke barrier by Roy C Door Company. 2) Completion date 8 23/2013 3) The Maintenance Director will assure continued compliance by testing all door closers monthly to assure proper function.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect all patients. Findings include: During facility tour between 10:00 AM and 12:30 PM on 08/13/2013, observation revealed that the kitchen and dining room are not properly separated from the adjoining corridor. The kitchen serving window does not have a fire shutter and the doors separating the dining area are not fire rated assemblies. This deficient practice was verified by the administrator at the time of the inspection.	K 029	**K 029** Corrective Action: 1) Latching hardware has been installed on the set of double doors and the single door separating the dining area and corridor. 2) Completion date 10/8/2013 3) The Maintenance Director will assure continued compliance by testing all door closers monthly to assure proper function.	