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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 6VZG
Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245459**

2. STATE VENDOR OR MEDICAID NO. (L2) **734769300**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

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) **02/01/2011**

6. DATE OF SURVEY **11/01/2013** (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) **12/31**

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (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
	65			
(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 :
Timothy Rhonemus, NFE NEII 11/21/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **11/20/2013** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

At the time of the extended survey completed on August 23, 2013 a complaint investigation was completed, H5459008, and was substantiated during this survey. Deficiency's were issued as a result of the substantiated findings at F353, also the facility was not in substantial compliance with the federal certification 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 for deficiency cited at F323, effective August 21, 2013

In addition, the facility would be subject to a loss ofNursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years, beginning August 23, 2013 as a result of an extended survey.

Refer to the CMS 2567b for both health and life safety code.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5459

February 25, 2014

Ms. Denise Becker, Administrator
Benedictine Living Community Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

Dear Ms. Becker:

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 October 15, 2013 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 9, 2013

Ms. Christina Gamaldi, Administrator
Benedictine Living Community Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459023, H5459008

Dear Ms. Gamaldi:

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 September 12, 2013, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F323, effective August 21, 2013. (42 CFR 488.430 through 488.444)

Also 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 23, 2013.

This was based on the deficiencies cited by this Department for an extended survey completed on August 23, 2013, that included an investigation of complaint number H5459008. Conditions in the facility constituted Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required.

On October 22, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 1, 2013 the 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 23, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 15, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our extended survey completed on August 23, 2013, as of October 15, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 15, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of September 12, 2013:

- Civil money penalty for the deficiency cited at F323, effective August 21, 2013, remain in effect. (42 CFR 488.430 through 488.444)

As we notified you in our letter of November 1, 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 23, 2013.

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.

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 5459r13.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245459	A. Building B. Wing	10/22/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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 F0323 Reg. # 483.25(h) LSC	10/07/2013	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	11/21/2013	19251	10/22/2013
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
8/23/2013		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245459	A. Building B. Wing	10/22/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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 **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**10/07/2013**	ID Prefix **F0205** Reg. # **483.12(b)(1)&(2)** LSC	**10/04/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**08/23/2013**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	**08/24/2013**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	**10/15/2013**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	**10/15/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	**10/04/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**10/07/2013**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	**10/15/2013**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	**09/26/2013**	ID Prefix **F0363** Reg. # **483.35(c)** LSC	**10/15/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**10/15/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	**10/01/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	**10/07/2013**	ID Prefix **F0496** Reg. # **483.75(e)(5)-(7)** LSC	**09/20/2013**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	11/21/2013	20794	10/22/2013

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/23/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245459	01 - MAIN BUILDING 01	11/1/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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 Reg. # **NFPA 101** LSC K0050	Correction Completed **09/19/2013**	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PS	12/09/2013	19251	11/01/20013
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
8/30/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245459	A. Building B. Wing 02 - NEW MAIN ENTRANCE	11/1/2013

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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 K0050	09/19/2013	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	12/09/2013	19251	11/01/2013
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
8/30/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6VZG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00352

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245459**

2. STATE VENDOR OR MEDICAID NO.
(L2) **734769300**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY WINSTED**
(L4) **551 FOURTH STREET NORTH**
(L5) **WINSTED, MN** (L6) **55395**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2011**

6. DATE OF SURVEY **08/23/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **70** (L18)

13. Total Certified Beds **70** (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
	70			
(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 :
Maryilyn Kaelke, HFE NE II 10/01/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcment 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
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

INVOLUNTARY
5- Fail to Meet Health/Safety
6- Fail to Meet Agreement

OTHER
7- Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/20/2013
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5459

At the time of the extended survey completed on August 23, 2013 a complaint investigation was completed, H5459008, and was substantiated during this survey. Deficiencies were issued as a result of the substantiated findings at F353, also the facility was not in substantial compliance with the federal certification 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.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5360

September 12, 2013

Ms. Christina Gamaldi, Administrator
Benedictine Living Community Winsted
551 Fourth Street North
Winsted, Minnesota 55395-0750

RE: Project Number S5459023

Dear Ms. Gamaldi:

On August 23, 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 23, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number H5459008.

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 a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

> **<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **<u>Substandard Quality of Care</u> - 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 23, 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:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

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, Benedictine Living Community Winsted is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective August 23, 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 23, 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 23, 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,

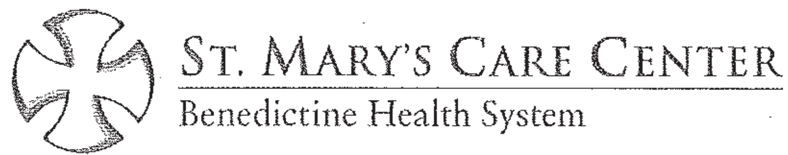
Colleen Leach

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117   Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File



September 25, 2013

Amendment to BLC-Winsted Plan of Correction

F225

R83/Stairwell: The Plant Operations Director adjusted the stairwell door to ensure the door properly closes on August 22, 2013. The facility additionally secured this door with the Roam Alert system on August 27th, 2013.

VA reports each will be audited when occurs to ensure reports are made timely to the Administrator and OHFC.

Correction Date: August 24th, 2013

F226

The facility has updated the abuse and prevention plan to include the definition of an injury of unknown origin. All staff of St. Mary's Care Center will receive training regarding the new policy and procedure to be completed by August 22, 2013 at 3 PM. Refer to F225 for more information

F246

All resident rooms were audited to ensure residents could access room and personal items. Rooms identified needing adjustment were re-organized to support resident function and preference.

F309

All residents will be reviewed to ensure proper pain management and to ensure a comprehensive assessment has been completed.

F323

R68 elopement assessment was updated on 8/21/13. Care plan has been updated with individual approaches for the resident.

F353

The facility will monitor the completion of care through weekly interviews with residents and family members to ensure adequate response times to resident care delivery. Results of these surveys will be brought to the QA meeting each month for analysis.

10/1/13
RK

See F244 for more information.

F356

The facility will audit the staffing posting weekly to ensure compliance. Results of these audits will be brought to the QA each month for analysis.

F441

Department managers will provide completed employee illness tracking forms for their department each week to the DON. The DON will compare the weekly employee illness logs to the resident illnesses to identify any cross contamination. Results of the weekly audits will be brought to the QA meeting each month.

F496

The facility audited and re-verified the registration of all nursing assistant employees on 8/24/13. The facility will continue to check verification for all new nursing assistant hires.

Respectfully Submitted,

Christina Haupt
Administrator/CEO
BLC-Winsted DBA St. Mary's Care Center

WINSTED: 551 4TH STREET NORTH, SUITE 101, WINSTED, MN 55395 t: 320-485-2151 f: 320-485-4241
www.stmaryscarecenter.org

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING ______ B. WING ______	C 08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 survey was conducted by the Minnesota Department of Health on August 19 through August 23, 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 21, 2013, at 5:10 p.m. and was removed on August 23, 2013, at 9:11a.m. A complaint investigation was completed at the time of the survey for complaint H5459008, and was substantiated during this survey. Deficiency's were issued as a result of the substantiated findings at F353. The facility's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	This Plan of Correction has been prepared and submitted timely and is St. Mary's Care Center Credible Allegation of Compliance. Submission of this Credible Allegation of Compliance is not legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of St. Mary's Care Center it's Administrator or any of its employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the Facility of the truth of any facts alleged or correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone	F 164	10/1/13 BT See addendum to POC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/CEO — (X6) DATE: 9·20·13

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 164	Continued From page 1 communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure privacy was provided during toilet use for 1 of 4 residents (R61) who was reviewed for privacy. Findings include: R61's diagnosis included dementia. The quarterly Minimum Data Set (MDS) dated 5/11/13, indicated she was cognitively intact, and needed staff assistance with transfers and toileting. R61's care plan revised 02/24/13, included "will self tx [transfer] to the bathroom... assist of 1 with FWW [front wheeled walker] for toileting." Resident	F 164	and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. F 164 The facility does ensure that residents have the right to personal privacy. Resident #61 was assessed for toileting status, including transfer during toileting, on 9/16/13. Per resident choice to self-transfer and self-toilet at times, R61, has been offered the use of the hallway bathroom to enable the closing of the door with wheelchair present. R61's care plan and care sheet was update to reflect the need to offer	

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F 164	Continued From page 2 Care Sheet, undated, included, "toilet, equip: FWW, often takes self, toilet schedule: takes self." The Urinary Incontinence Care Area Assessment (CAA) dated 11/13/12, included "currently requires assist of 1 with FWW and gait belt. Alerts staff of needs. At times will self transfer... does need reminders and encouragement and assist during night hours." R61 resides in a semi- private room with no roommate since 07/15/13. When interviewed on 8/20/13 at 8:41 a.m. R61 stated, she has difficulty when using her bathroom, which is located in her room. "I can't close the door to the bathroom when I use my wheelchair... I don't have any privacy." R61 stated, "I don't have a roommate now, but I did about a month ago." R61 stated she wanted more privacy when using the bathroom and was not aware of a resident bathroom in hallway that provided more privacy and could accommodate her wheelchair. During the environmental tour on 8/23/13, at 9:00 a.m. the director of environmental services (DES) and a maintenance tech (MT)-A, verified that some resident bathrooms are not large enough for residents who utilize wheelchairs and/or walkers to close the door behind them for privacy while using the toilet. DES stated, "maybe we [staff] just haven't offered the hallway resident bathroom." When interviewed on 8/23/13, at 2:05 p.m. registered nurse (RN)-B stated R61 needs assistance of one staff to use the bathroom, but often chooses to take herself to the bathroom, which means R61's wheelchair blocks the bathroom door from being closed and does not	F 164	the hallway bathroom when self-transferring per resident's request. All residents who use a wheelchair and self-transfer for toileting are at risk. The DON or designee will monitor privacy issues related to toileting via 5 weekly interviews of those residents who self-transfer for toileting. The facility's Resident Rights Guidelines for All Nursing Procedures was updated to include the steps for provision of privacy with self-transferring and toileting number six, section "c". Review of the policy will be provided to all nursing staff 10/4/13. The Social Worker will monitor/review interview audit results to ensure compliance with privacy. Results of audits will be reviewed at Quality Assurance (QA) meetings each month. Completion Date: October 7th, 2013	

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F 164	Continued From page 3 allow any privacy for R61 from roommate. RN-B stated, "if [R61] would use her call light, staff would assist her onto the toilet, remove the wheelchair and close the bathroom door for privacy." RN-B did confirm R61's last roommate was on 7/15/13 and that using the hallway resident bathroom had not been offered to R61 for more privacy. Although the facility provided a separate bathroom in the resident's room, the facility failed to ensure privacy was maintained while using the bathroom, or offer resident the larger, more private bathroom across the hallway. A facility policy was requested, but not received from the facility.	F 164	F 205 The facility does ensure that before a resident transfers to the hospital or goes on a therapeutic leave the facility provides written information to the resident and family member. All residents at the facility were identified at risk. Bed hold information is provided to each resident upon admission. The bed hold policy and procedure has been updated to reflect the staff members responsible for the 24 hour notice for those with an emergent transfer situation. All nursing staff will be re-educated regarding the expectation and policy to have a bed hold signed during the time of the transfer and/or to send the bed hold form with the resident/family at the time of transfer. Education will also be provided to the Social Worker and Health Unit Coordinators. Training will be completed by 10/4/13.	
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy	F 205		

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F 205	Continued From page 4 described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a Notice of Bed Hold and Readmission for 2 of 5 residents (R6 and R19) who were transferred to a hospital. In addition, the facility failed to ensure a system was in place, and consistent, to provide bed hold notices in a timely fashion. This had the potential to affect all 60 of 60 current residents who may be hospitalized or go on therapeutic leave. Findings include: During interview on 8/20/13, at 2:09 p.m. family member (F)-A stated the facility had not given him any information on a bed hold, when his family member (R24) had been transferred to a hospital on 7/9/13. R24's medical record indicated R24 had been transferred to the hospital emergency room, but had returned to the facility within 24 hours. Therefore, R24 had not required this notice. R6 was transferred to a hospital on 7/20/13. A Bed Hold Policy Notification was signed by the facilities social worker (SW) on 7/22/13, two days after R6 was transferred to the hospital. This notice was signed by R6's representative on 8/9/13, 19 days after they were transferred to the hospital. There was no indication in the medical record that R6's family was given information about the bed hold until 8/9/13. R19 was transferred to a hospital on 7/13/13. A Bed Hold Policy Notification was signed by R19	F 205	The DON will audit emergent transfers and leaves of absence each month to ensure bed hold policy and procedures were followed. Results of the audit will be brought to the Quality Assurance (QA) meeting each month. DON will monitor for ongoing compliance. Completion Date: October 4, 2013	

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F 205	Continued From page 5 on 7/30/13, seven days after they were transferred. The SW signed the notice on 7/13/13, a Saturday. However, the 7/15/13 Resident Progress Notes by the SW indicated; "Verbal bed hold received." The Resident Progress Note did not identify the date the resident/family was given the information about the bed hold or which family member they spoke to. During interview with registered nurse (RN)-A on 8/22/13, at 9:45 a.m. stated if a resident is being sent to the emergency room, we will "call family and ask for a verbal bed hold agreement from them at the time of transfer, in case they are hospitalized." If the nurses didn't get the bed hold agreement right away, or forgot to send it with to the hospital, the health unit coordinators (HUC) would take care of it in the morning. When interviewed on 8/22/13, at 9:53 a.m. HUC-A stated, "Usually social services takes care of that; if it's the weekend, the charge nurse would the next day." When interviewed on 8/22/13, at 9:58 a.m. the business office manager, stated, "Social services calls the family to see if they want to hold the bed." If it is the weekend, this would happen on Monday. When interviewed on 8/22/13, at 10:18 a.m. RN-B stated the social worker was in charge of the bed hold agreements. Nursing does not do anything with them. When interviewed on 8/22/13, at 10:27 a.m. SW stated there are bed hold forms at the nurses station and this notice should be sent with to the	F 205		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 205	Continued From page 6 hospital. The nurses should contact the family to see if they want to hold the bed at the time of transfer. The form would be mailed to the responsible party if they would not be in the facility for a while. If a nurse has received a verbal bed hold, they should document this in the progress notes. The social worker stated she might have been in the building on 7/13/13, a Saturday, to give the bed hold notice for R19, but could not be sure. She was uncertain why the date on the form was 7/13/13, but the date in progress note wasn't until Monday 7/15/13. Review of the facility policy entitled Bed Hold-Hospital and Therapeutic Leave dated December 2002, included under procedure, number 2. "Prior to or at the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident, responsible party or legal representative written notice which restates and specifies the duration of the bed hold policy. If that is not possible do to extenuating circumstances (i.e. resident has gone to the hospital for an emergency), communicate the information by telephone to the resident or responsible party and follow up by mailing the authorization/request form and obtaining the signed form for facility record." Number "3. For emergency hospital transfers, the responsible party or legal representative is provided with written notification within 24 hours of the transfer."	F 205	F 225 The facility does 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 other officials in accordance with State law through established procedures. The facility does have evidence that all alleged violations are thoroughly investigated. The facility does ensure that results of all investigations are reported to the administrator or her designated representative and other officials in accordance with State law. R83 care sheet was updated to reflect the use of the Roam Alert Tag and its location. R83 care plan was updated to reflect the use of the Roam Alert Tag on 9/16/13, the location of the tag and the need to verify the function of the Tag daily. The tag placement and	
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 mistreating residents by a court of law; or have	F 225		

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F 225	Continued From page 7 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 interview and document review, the facility failed to ensure all allegations of abuse, neglect, and injuries of unknown origin, were thoroughly investigated and immediately reported	F 225	function is checked daily. The elopement assessment was updated for R83 on 8/21/13. The staff involved in the failure to report the incident involving R83 in the stair well were in-serviced on the need to immediately report any such occurrences immediately to the Administrator. R47's concern was addressed via interview on 8/22/13. Resident denied any fears or concerns with staff or family. Bruising was assessed by the nursing staff and OT. OT aided in w/c positioning on 8/23/13. The LPN was in-serviced on the proper reporting procedures to immediately notify the Administrator of any abuse, neglect, involuntary seclusion, exploitation/misappropriation of resident funds, catastrophic reaction, resident to resident altercation, elopement, missing resident and injury of unknown origin. R35's concern was addressed via interview on 6/20/12 resulting in	

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F 225	Continued From page 8 to the administrator and State Agency (SA) for 4 of 5 residents (R83, R47, R35 & R53) allegations reviewed. Findings include: R83 had eloped from the secured memory care unit. This incident was not immediately reported to the administrator or state agency, nor was the incident thoroughly investigated to determine possible cause. R83 diagnoses included frontotemporal dementia, agitation and depression. R83's most recent quarterly Minimum Data Set (MDS) dated 5/22/13, indicated he was cognitively intact, ambulated independently and wandered one to three days of the seven day assessment period. R83's care plan dated 2/26/13, indicated R83's cognitive function varied throughout the day. The care plan also included, "he is at risk for elopement as he was wandering from home previously." Staff were directed to monitor and assess for elopement, and to provide supervision off of the unit, and to monitor "whereabouts Q30 [every 30] minutes." The care plan also identified R83 had a WanderGuard bracelet to his left wrist to alert staff of possible elopement. The nursing assistant Resident Care Sheet, undated, did not identify R83 had any WanderGuard bracelet. When interviewed on 8/21/13, at 9:22 a.m. health unit coordinator (HUC)-A stated approximately six months ago (prior to a 4/28/13 elopement incident) R83 had went through the first floor secure stairwell door, behind custodian (C)-A, and was seen through the second floor door window in the stairwell. "I told C-A immediately	F 225	notification to state officials and the local police department. Employee was immediately suspended and terminated from employment and reporting employee was counseled and re-educated regarding the requirements of immediate reporting. R53's concern was addressed on 8/23/13. Incident was reported to state agency. Investigation did not find evidence of intent. Result was a change in the assignment sheet to abide by the resident's wishes regarding not working with the caregiver involved. Facility will conduct audits of incident reporting, specific to immediate reporting notification compliance. Monthly all reportable events will be audited for adherence to the immediately requirements. Results of the audits will be brought to the Quality Assurance (QA) meeting. All staff were re-educated to the Vulnerable Adult Reporting	

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

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F 225	Continued From page 9 that R83 was behind him." HUC-A stated, the stairwell between first and second floor does not have an WanderGuard system. It has a separate locking system which must have a code punched in to be able to open. When interviewed on 8/21/13, at 9:55 a.m. C-A stated there was an incident in the stairwell, several months ago, unsure of date. He was going up the stairway and the door did not latch behind him, on the first floor secured memory care unit, and R83 followed him up the stairwell. "It scared the living heck out of me, he was right behind me, every time I look now." R83's medical record did not identify R83 had been found in the stairwell, off the secured memory care unit, by C-A and HUC-A. During observation on 8/19/13, at 3:20 p.m. the stair well door, on the secured memory care unit, that led to the second floor was opened and allowed to shut on its own with a self closure on the door frame. After the door was shut for 15 seconds, the secured door was easily opened without the use of the security code to open the door. Again on 8/19/13, at 5:01 p.m., on 8/19/13, at 7:40 p.m., and on 8/22/13, at 9:40 a.m., the same stair well door on the secured memory care unit, was opened and allowed to close on its own. After it was shut for 15 seconds, the door was easily opened without the use of the security code. When interviewed on 8/21/13, at 9:28 a.m. nursing assistant (NA)-A stated R83 had gotten out of the building, and "you have to make sure the secure locking stairwell door by the elevator shuts behind you, because it does not always	F 225	Policy, which addresses immediate notification requirements, by 8/22/13 Ongoing training/review will be conducted upon hire and annually. DON/Designee will monitor for on-going compliance. Completion Date: August 23rd, 2013	

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F 225	Continued From page 10 latch." When interviewed on 8/21/13, at 9:33 a.m. NA-B stated she did not recall anyone actually getting out of the locked unit. However, NA-B stated, "all staff know to check and make sure the stairwell door shuts behind you, because it does not always latch." When interviewed on 8/22/13, at 2:30 p.m. the administrator stated she was not aware R83 had been found in the stairwell, off the secured memory unit. The incident had not been reported to her or the state agency. Although the facility was aware R83 had eloped through the stairwell, the administrator and state agency had not been notified. The incident had not been investigated to determine cause, or to prevent further elopement by R83. The facility staff were aware the secured stairwell door did not always properly latch, creating a possible exit for elopement. R83 had eloped from the facility, a thorough investigation was not completed to determine the actual cause of R83's elopement. R83's Elopement Risk Assessment dated 2/14/13 indicated he had elopement successes in the past, wandering with no rational purpose and attempted to open doors. The assessment also indicated he has a WanderGuard bracelet and was at high risk for elopement. Review of the facility Vulnerable Adult (VA) Report dated 4/28/13, included "visitors on the first floor memory care locked unit, family of another	F 225		

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F 225	Continued From page 11 resident. [R83]was found by the memory care nurse while on her break on the sidewalk outside of the facility unharmed, looking for the [library]." The VA report indicated the alarm had not reset when R83 followed the visitors up and out the doors. The administrator was immediately notified of the 4/28/13 elopement incident. The facility VA Investigative Report dated 5/1/13, included R83 was independent with ambulation and needed a secured unit due to his dementia. The investigation identified several visitors were in the building during the time of R83's elopement, including two children between 8-10 years old, as possible suspects of allowing R83 to get onto the elevator and leave the building. The VA Report further indicated the facility "...counseled the parents and children..." who they felt were involved in R83's elopement, by the nurse to make sure they kept residents secure and safe. The administrator and state agency were immediately notified of the incident. During interview on 8/21/13, at 11:30 a.m. the maintenance technician (MT)-A stated the facility had suspected a family members children were inputting the code by the elevator to release the elevator to go up to the second floor and allowed R83 to get into the elevator. But when a resident has a WanderGuard bracelet on and gets close to the elevator it sounds, alerting staff. MT-A continued to state, there was a separate code only staff know, which prevents the residents WanderGuard bracelet from sounding when they entered the elevator, so they can transport them to medical appointments or family outings. The children would not have known this code, so the WanderGuard system should have alarmed. The MT further stated they have been having	F 225		

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F 225	Continued From page 12 problems with the elevators WanderGuard system making a "chirping sound," so they contacted the WanderGuard company, who came out in March 2013 to look at the WanderGuard system. The company found there were too many radio frequencies, which interfered with the WanderGuard system. Review of Facility Visit Report from Stanley Health Care, who came to fix the WanderGuard system, dated 3/29/13, included, "Site has poor range on lower level elevator door, excessive Electromagnetic Interference [EMI]. ...which is causing issues, not able to track down at this time. Site may also try to relocate main/aux antenna but noise is throughout the area..." There were no additional reports that identified the problem with the WanderGuard system had been addressed or fixed. During telephone interview on 8/22/13, at 12:22 p.m. a Stanley Health Care representative stated she had spoken with the technician that had been out to the facility on 3/29/13, and he was unable to fix the problem due to excessive EMI. "The EMI's can cause false alarms or prevent the unit from working at all." The representative stated EMI can be caused from a truck parked out side with a two way radio, the facilities two way radios the staff use, humidity, and many other reasons. The only way the facility could fix the problem is if they were to replace the unit they have. There was no indication that further changes or upgrades had been completed to the WanderGuard system, since the 3/29/13 visit from Stanley Health Care, even though the system continued to have excessive EMI, causing the system to potentially malfunction.	F 225		

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Continued From page 13

When interviewed on 8/22/13, at 2:30 p.m. the administrator stated she was aware of R83 eloping from the facility in April 2013, and felt some children were playing on the elevator, when R83 had eloped from the facility using the elevator to get to the second floor. The administrator was aware of the WanderGuard system not functioning properly in March 2013, but was not aware the system could be replaced to eliminate the problems with EMI.

The facility did not complete a thorough investigation to determine, how R83 eloped when they were aware the WanderGuard system was not functioning properly since March 2013.

R47 had a bruise of unknown origin which was not immediately reported to the administrator, state agency nor was it thoroughly investigated.

R47 was observed on 8/20/13, at 9:18 a.m. and a fading purple bruise was noted above her right elbow on outer arm. R47 stated she was not sure how she got the large bruise.

R47's diagnoses included diabetes and dementia. The quarterly MDS dated 5/2/13, indicated she was cognitively intact, and required extensive to total assistance from staff for all activities of daily living (ADL's). R47's care plan dated 10/15/09, included potential for bleeding complications due to Coumadin (a blood thinner) use. Two assist and mechanical lift for transfers.

R47 had a Skin Integrity Events-Bruise form dated 8/4/13. The form indicated there were two bruises noted on her upper right arm. The

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bruising measured 2 x 2 centimeters (cm), and 13 x 7 cm. The bruises were "purplish-Black" in color..."

R47's progress notes revealed the following:
8/4/13, 3:31 p.m. "Resident was gone yesterday with family. Did skin assessment. Resident has new bruises on R (right) upper arm. Measuring 13 x7 cm and 2 x 2 cm...Called [family] and notified [them] about bruise. [Family] states that [family] does not think the resident got the bruise while out yesterday. Resident states that it began hurting this AM [morning] but doesn't recall what could have caused the bruise."
8/4/13, 1:06 p.m. "right upper arm bruise remains purple/blue/red. Does feel like a lump under the bruise..."

When interviewed on 8/21/13, at 2:00 p.m. the administrator stated she did not have a report on the bruising on R47 from 8/4/13. This had not been reported to her, it was not a reportable bruise. "She left here with her [family], she didn't have any bruises, she came back and had bruises, it didn't happen here." After discussing the extent of the bruising with the amount of pain the resident had, the residents and [family] denial of bruising happened while gone from the facility, the administrator agreed it should have been reported and investigated further.

When interviewed on 8/22/13, at 1:45 p.m. licensed practical nurse (LPN)-A stated if a resident can not say what happened, and no one saw it, and they have a bruise, she reports it to the registered nurse (RN) if there is one working. If no RN, she will report to the administrator. She was aware of R47's bruise on 8/4/13, and thought it was from her leaning on the right arm while

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F 225	Continued From page 15 seated in the chair. She had also been out with family the day before. It could have happened while out of the building. When interviewed on 8/22/13, at 2:00 p.m. RN-A stated R47 had been out with her family the day before discovering the bruises, so it was assumed it had happened while he was transferring her in/out of the car. RN-A then stated R47 leans in her wheel chair to the right side and the bruise could be from this. She had not investigated further. R47 had not been out over night with the family. RN-A stated they had asked the resident if anything happened while out with her family, or if she was afraid, and R47 had said no. She had not documented this conversation. RN-A had contacted the family to ask him to sign a risk versus benefits statement regarding the family for transferring R47 themselves, because in the facility R47 requires two assist and a mechanical lift for all transfers. The family transfers her with one person. RN-A had not offered any training to the family on safe transfer techniques. Nor had she determined if this bruise had anything to do with family transferring her or not. R47 was observed for a transfer on 8/22/13, at 4:00 p.m. and once in her wheel chair, her right upper arm did not touch the chair in the area where the bruising was noted. Even though R47 was cognitively intact and was unsure how the bruise occurred but did not happen when out with family. The family also stated she did not get the bruise while she was with them. The facility failed to report injuries of unknown origin to the administrator and state agency, also there was no investigation	F 225		

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F 225	Continued From page 16 completed to determine possible cause. R35 had made allegations of physical/verbal abuse that was not reported immediately to the administrator or the state agency after the incident occurred. R35 diagnosis included dementia. The quarterly MDS dated 05/31/13, identified R35 had severe cognitive impairment and required extensive assistance from staff with all ADL's. Review of incident report by director of nursing (DON), dated 06/21/13, indicated, "On 06/20/12 I [DON] was notified that an employee on the night shift was being "verbally and physically abusive" to the resident on the memory care floor. I [DON] immediately notified the administrator and reported the alleged matter to OHFC [Office of Health Facility Complaints] and CEP [Common Entry Point] and began the investigation. The employee was then notified of an alleged incident that required investigation and was put on suspension during this time.... I was informed by [registered nurse- (RN)-C] on 06/20/12... reported most recent event relating to [R35] occurred on 06/18/12. I asked her why she waited until 06/20/12 to report as the policy clearly states immediate notification is required. She stated awareness of the policy and that she said, "That's why I am notifying you now." I [DON] responded that immediate, means right now. I did a corrective action with RN-C in regards to her failure to make immediate notification. She willingly signed the corrective action and stated understanding of her error... It was alleged that the employee had "slapped" the facial cheeks of a resident [R35] and said "look at those chubby	F 225		

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cheeks." Upon investigation, I [DON] was informed by the employee who was with the alleged perpetrator at the time of this occurrence that the she "patted" her cheeks and said, "Hey fatty, isn't she getting fatter"... I [DON] discussed the alleged behavior with the clinical manager, no injuries of unknown origin were found with any residents that may be indicative of abuse... I [DON] did not find any evidence of substation of any physical abuse as originally reported to me. I [DON] did find that evidence exists of inappropriate language and statements towards the memory care residents on the first floor not in keeping with the core values of St. Mary's Care center..."

When interviewed on 8/21/13 at 9:20 .am. the administrator stated the incident regarding R35 had been reported to OHFC and the police called, but they didn't come out stating a crime had not been committed. The administrator verified RN-C should have "immediately" reported the incident, but it was reported by DON to the state agency on 6/20/12, two days after the alleged incident.

R53 made allegations of physical and verbal abuse which was not reported immediately to the state agency, and were not investigated.

R53's diagnoses included left hemiplegia [paralysis], personality disorder, and chronic pain. The quarterly MDS dated 8/6/13, indicated R53 was cognitively intact and required extensive assist for all activities of daily living (ADL)'s except eating.

When interviewed on 8/20/13, at 9:50 a.m. R53 stated a trained medication aide (TMA)-C, was rude and "mouthy" with me as well as "physical."

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F 225	Continued From page 18 R53 stated she had called for her insulin and TMA-C told her to "be patient." Then TMA-C assisted her into her wheel chair with a mechanical lift. While tucking the sling into her wheel chair, TMA-C had scratched her skin with her rings and fingernails. R53 had reported this to RN-B. When TMA-C returned, TMA-C stated, "You little rat, why did you tell on me." R53 then asked RN-B to not allow TMA-C to care for her any more. RN-B replied, "Well, if we don't have [TMA-C] help you, there may not be anyone to help you." R53 could not recall when this incident occurred, but TMA-C continues to care for her. When interviewed on 8/21/13, at 1:44 p.m. the social service director (SS)-C stated she knew R53 and TMA had "head butting," but was not aware of an exact accusation. She had not interviewed R53 to find out what this "head butting" was all about. The above incident was reported to social services (SS)-C by the surveyor at this time. When interviewed on 8/21/13, at 2:11 p.m. RN-B stated R53 never reported to her she did not want TMA-C to care for her. She was not aware of the incident described by R53 until today. When interviewed on 8/22/13, at 1:25 p.m. the director of nursing (DON) stated she was not aware of the R53's accusation of verbal and physical abuse and did not know of any request for TMA-C to not work with her. DON stated if she had known, she would have accommodated R53's request. When interviewed on 8/22/13, at 2:07 p.m., SS-C stated she was not aware of the accusation until "yesterday" and stated as of today "she did not do	F 225		

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F 225	Continued From page 19 anything and nothing had been reported." SS-C verified the incident was not yet reported nor was an investigation had been started regarding this allegation of verbal and physical abuse. When interviewed on 8/23/13, at 9:05 a.m. the administrator stated she knew nothing of R53's allegations until yesterday. She had not reported it to the state agency or had started an investigation to date. Although R53's accusation of verbal and physical abuse had been reported to staff on 8/21/13, at 1:44 p.m. the facility did not immediately reported the allegation to the state agency, nor was an investigation started.	F 225	F 226 The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriate of resident property. R83 care sheet was updated to reflect the use of the Roam Alert Tag and its location. R83 care plan was updated to reflect the use of the Roam Alert Tag on 9/16/13, the location of the tag and the need to verify the function of the Tag daily. The tag placement and function is checked daily. The elopement assessment was updated for R83 on 8/21/13.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to develop and implement an abuse prohibition policy which required a thorough investigation of any alleged abuse, neglect, or injuries of unknown origin, and immediate notification to the administrator and state agency for 4 of 5 residents, (R83, R47, R35 and R53) allegations reviewed. The facility policy failed to include any definition of injures of unknown origin.	F 226	The staff involved in the failure to report the incident involving R83 in the stair well were in-serviced on the need to immediately report any such occurrences immediately to the Administrator. R47's concern was addressed via interview on 8/22/13. Resident denied any fears or concerns with	

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F 226	Continued From page 20 Findings include: The Facility Abuse Prevention Plan, updated 6/27/12 included, "Any employee or volunteer must report suspected maltreatment if: 1. He/she has knowledge of maltreatment of a vulnerable adult 2. Has reasonable cause to believe that a vulnerable adult has been maltreated 3. Has knowledge that a vulnerable adult has sustained an injury not reasonably explained by a history of such injury." The policy further included, "the supervisor must immediately report all suspected maltreatment to the Administrator. The Director of Nursing or Administrator will process the report. Must report immediately to OHFC (Office Of Facility Health Complaints)..." The policy further included, "The Administrator, Director of Nursing/Designee (others as identified) are responsible for immediate review, investigation and reporting all suspected cases of maltreatment." The policy did not have a definition of injuries of unknown origin. R83 had eloped from the secured memory care unit. This incident was not immediately reported to the administrator or state agency, nor was the incident thoroughly investigated to determine possible cause as identified by the facility policy. R83 diagnoses included frontotemporal dementia, agitation and depression. R83's most recent quarterly Minimum Data Set (MDS) dated 5/22/13, indicated he was cognitively intact, ambulated independently and wandered one to three days of the seven day assessment period.	F 226	staff or family. Bruising was assessed by the nursing staff and OT. OT aided in w/c positioning on 8/23/13. The LPN was in-serviced on the proper reporting procedures to immediately notify the Administrator of any abuse, neglect, involuntary seclusion, exploitation/misappropriation of resident funds, catastrophic reaction, resident to resident altercation, elopement, missing resident and injury of unknown origin. R35's concern was addressed via interview on 6/20/12 resulting in notification to state officials and the local police department. Employee was immediately suspended and terminated from employment and reporting employee was counseled and re-educated regarding the requirements of immediate reporting. R53's concern was addressed on 8/23/13 Incident was reported to state agency. Employee was suspended pending the	

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F 226	Continued From page 21 R83's care plan dated 2/26/13, indicated R83's cognitive function varied throughout the day. The care plan also included, "he is at risk for elopement as he was wandering from home previously." Staff were directed to monitor and assess for elopement, and to provide supervision off of the unit, and to monitor "whereabouts Q30 [every 30] minutes." The care plan also identified R83 had a WanderGuard bracelet to his left wrist to alert staff of possible elopement. The nursing assistant Resident Care Sheet, undated, did not identify R83 had any WanderGuard bracelet. When interviewed on 8/21/13, at 9:22 a.m. health unit coordinator (HUC)-A stated approximately six months ago R83 had went through the first floor secure stairwell door, behind custodian (C)-A, and was seen through the second floor door window in the stairwell. "I told C-A immediately that R83 was behind him." HUC-A stated, the stairwell between first and second floor does not have an WanderGuard system. It has a separate locking system which must have a code punched in to be able to open. When interviewed on 8/21/13, at 9:55 a.m. C-A stated there was an incident in the stairwell, several months ago, unsure of date. He was going up the stairway and the door did not latch behind him, on the first floor secured memory care unit, and R83 followed him up the stairwell. "It scared the living heck out of me, he was right behind me, every time I look now." R83's medical record did not identify R83 had been found in the stairwell, off the secured memory care unit, by C-A and HUC-A. During observation on 8/19/13, at 3:20 p.m. the	F 226	investigation. Investigation did not find evidence of intent. Result was a change in the assignment sheet to abide by the resident's wishes regarding not working with the caregiver involved. Facility will conduct audits of incident reporting, specific to immediate reporting notification compliance. Monthly all reportable events will be audited for adherence to the immediately requirements. Results of the audits will be brought to the Quality Assurance (QA) meeting. All staff will be re-educated to the Vulnerable Adult Reporting Policy, which has been updated to include the definition of an injury of unknown origin by 8/22/13. Ongoing training/review will be conducted upon hire and annually. DON/Designee will monitor for on-going compliance. Completion Date: August 23rd, 2013	

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F 226	Continued From page 22 stair well door, on the secured memory care unit, that led to the second floor was opened and allowed to shut on its own with a self closure on the door frame. After the door was shut for 15 seconds, the secured door was easily opened without the use of the security code to open the door. Again on 8/19/13, at 5:01 p.m., on 8/19/13, at 7:40 p.m., and on 8/22/13, at 9:40 a.m., the same stair well door on the secured memory care unit, was opened and allowed to close on its own. After it was shut for 15 seconds, the door was easily opened without the use of the security code. When interviewed on 8/21/13, at 9:28 a.m. nursing assistant (NA)-A stated R83 had gotten out of the building, and "you have to make sure the secure locking stairwell door by the elevator shuts behind you, because it does not always latch." When interviewed on 8/21/13, at 9:33 a.m. NA-B stated she did not recall anyone actually getting out of the locked unit. However, NA-B stated, "all staff know to check and make sure the stairwell door shuts behind you, because it does not always latch." When interviewed on 8/22/13, at 2:30 p.m. the administrator stated she was not aware R83 had been found in the stairwell, off the secured memory unit. The incident had not been reported to her or the state agency. Although the facility was aware R83 had eloped through the stairwell, the administrator and state agency had not been notified. The incident also had not been investigated to determine cause, or to prevent further elopement by R83. The facility	F 226		

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F 226	Continued From page 23 staff were aware the secured stairwell door did not always properly latch, creating a possible exit for elopement. R83 had eloped from the facility, a thorough investigation was not completed to determine the actual cause of R83's elopement as directed by the facility policy. R83's Elopement Risk Assessment dated 2/14/13 indicated he had elopement successes in the past, wandering with no rational purpose and attempted to open doors. The assessment also indicated he has a WanderGuard bracelet and was at high risk for elopement. Review of the facility Vulnerable Adult (VA) Report dated 4/28/13, included "visitors on the first floor memory care locked unit, family of another resident. [R83]was found by the memory care nurse while on her break on the sidewalk outside of the facility unharmed, looking for the [library]." The VA report indicated the alarm had not reset when R83 followed the visitors up and out the doors. The administrator was immediately notified of the 4/28/13 elopement incident. The facility VA Investigative Report dated 5/1/13, included R83 was independent with ambulation and needed a secured unit due to his dementia. The investigation identified several visitors were in the building during the time of R83's elopement, including two children between 8-10 years old, as possible suspects of allowing R83 to get onto the elevator and leave the building. The VA Report further indicated the facility "...counseled the parents and children..." who they felt were involved in R83's elopement, by	F 226		

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the nurse to make sure they kept residents secure and safe. The administrator and state agency were immediately notified of the incident.

During interview on 8/21/13, at 11:30 a.m. the maintenance technician (MT)-A stated the facility had suspected a family members children were inputting the code by the elevator to release the elevator to go up to the second floor and allowed R83 to get into the elevator. But when a resident has a WanderGuard bracelet on and gets close to the elevator it sounds, alerting staff. MT-A continued to state, there was a separate code only staff know, which prevents the residents WanderGuard bracelet from sounding when they entered the elevator, so they can transport them to medical appointments or family outings. The children would not have known this code, so the WanderGuard system should have alarmed. The MT-A further stated they have been having problems with the elevators WanderGuard system making a "chirping sound," so they contacted the WanderGuard company, who came out in March 2013 to look at the WanderGuard system. The company found there were too many radio frequencies, which interfered with the WanderGuard system.

Review of Facility Visit Report from Stanley Health Care, who came to fix the WanderGuard system, dated 3/29/13, included, "Site has poor range on lower level elevator door, excessive Electromagnetic Interference [EMI]. ...which is causing issues, not able to track down at this time. Site may also try to relocate main/aux antenna but noise is throughout the area..." There were no additional reports that identified the problem with the WanderGuard system had been addressed or fixed.

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F 226	Continued From page 25 When interviewed on 8/22/13, at 2:30 p.m. the administrator stated she was aware of R83 eloping from the facility in April 2013, and felt some children were playing on the elevator, when R83 had eloped using the elevator to get to the second floor. The administrator was aware of the WanderGuard system not functioning properly in March 2013, but was not aware the system could be replaced to eliminate the problem's with EMI. The facility did not complete a thorough investigation as directed by the facility policy to determine, how R83 eloped when they were aware the WanderGuard system was not functioning properly since March 2013. R47 had a bruise of unknown origin which was not immediately reported to the administrator, stage agency nor was it thoroughly investigated as identified by the facility policy. R47 was observed on 8/20/13, at 9:18 a.m. and a fading purple bruise was noted above her right elbow on outer arm. R47 stated she was not sure how she got the large bruise. R47's diagnoses included diabetes and dementia. The quarterly MDS dated 5/2/13, indicated she was cognitively intact, and required extensive to total assistance from staff for all activities of daily living (ADL's). R47's care plan dated 10/15/09, included potential for bleeding complications due to Coumadin (a blood thinner) use. Two assist and mechanical lift for transfers. R47 had a Skin Integrity Events-Bruise form dated 8/4/13. The form indicated there were two	F 226		

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F 226	Continued From page 26 bruises noted on her upper right arm. The bruising measured 2 x 2 centimeters (cm), and 13 x 7 cm. The bruises were "purplish-Black" in color..." R47's progress notes revealed the following: 8/4/13, 3:31 p.m. "Resident was gone yesterday with family. Did skin assessment. Resident has new bruises on R (right) upper arm. Measuring 13 x7 cm and 2 x 2 cm...Called [family] and notified [them] about bruise. [Family] states that [family] does not think the resident got the bruise while out yesterday. Resident states that it began hurting this AM [morning] but doesn't recall what could have caused the bruise." 8/4/13, 1:06 p.m. "right upper arm bruise remains purple/blue/red. Does feel like a lump under the bruise..." When interviewed on 8/21/13, at 2:00 p.m. the administrator stated she did not have a report on the bruising on R47 from 8/4/13. This had not been reported to her, it was not a reportable bruise. "She left here with her [family], she didn't have any bruises, she came back and had bruises, it didn't happen here." After discussing the extent of the bruising with the amount of pain the resident had, the residents and [family] denial of bruising happened while gone from the facility, the administrator agreed it should have been reported and investigated further. When interviewed on 8/22/13, at 1:45 p.m. licensed practical nurse (LPN)-A stated if a resident can not say what happened, and no one saw it, and they have a bruise, she reports it to the registered nurse (RN) if there is one working. If no RN, she will report to the administrator. She	F 226		

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F 226	Continued From page 27 was aware of R47's bruise on 8/4/13, and thought it was from her leaning on the right arm while seated in the chair. She had also been out with family the day before. It could have happened while out of the building. When interviewed on 8/22/13, at 2:00 p.m. RN-A stated R47 had been out with her family the day before discovering the bruises, so it was assumed it had happened while he was transferring her in/out of the car. RN-A then stated R47 leans in her wheel chair to the right side and the bruise could be from this. She had not investigated further. R47 had not been out over night with the family. RN-A stated they had asked the resident if anything happened while out with her family, or if she was afraid, and R47 had said no. She had not documented this conversation. RN-A had contacted the family to ask him to sign a risk versus benefits statement regarding the family for transferring R47 themselves, because in the facility R47 requires two assist and a mechanical lift for all transfers. The family transfers her with one person. RN-A had not offered any training to the family on safe transfer techniques. Nor had she determined if this bruise had anything to do with family transferring her or not. R47 was observed for a transfer on 8/22/13, at 4:00 p.m. and once in her wheel chair, her right upper arm did not touch the chair in the area where the bruising was noted. Even though R47 was cognitively intact and was unsure how the bruise occurred but did not happen when out with family. The family also stated she did not get the bruise while she was with them. The facility failed to report injuries of	F 226		

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unknown origin to the administrator and state agency, also there was no investigation completed to determine possible cause as directed by the facility policy.

The facility policy, entitled Facility Abuse Prevention Plan, updated 6/27/12, did not include any definition of injuries of unknown origin.

R35 had made allegations of physical/verbal abuse to a RN-C, who did not immediately report the incident to the administrator or to the state agency per facility policy.

R35 diagnosis included dementia. The quarterly MDS dated 05/31/13, identified R35 had severe cognitive impairment and required extensive assistance from staff with all ADL's.

Review of incident report by director of nursing (DON), dated 06/21/13, indicated, "On 06/20/12 I [DON] was notified that an employee on the night shift was being "verbally and physically abusive" to the resident on the memory care floor. I [DON] immediately notified the administrator and reported the alleged matter to OHFC [Office of Health Facility Complaints] and CEP [Common Entry Point] and began the investigation. The employee was then notified of an alleged incident that required investigation and was put on suspension during this time.... I was informed by [registered nurse- (RN)-C] on 06/20/12... reported most recent event relating to [R35] occurred on 06/18/12. I asked her why she waited until 06/20/12 to report as the policy clearly states immediate notification is required. She stated awareness of the policy and that she [said] "that's why I am notifying you now." I [DON] responded

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F 226	Continued From page 29 that immediate, means right now. I did a corrective action with RN-C in regards to her failure to make immediate notification. She willingly signed the corrective action and stated understanding of her error... It was alleged that the employee had "slapped" the facial cheeks of a resident [R35] and said "look at those chubby cheeks." Upon investigation, I [DON} was informed by the employee who was with the alleged perpetrator at the time of this occurrence that the she "patted" her cheeks and said "hey fatty, isn't she getting fatter"... I [DON] discussed the alleged behavior with the clinical manager, no injuries of unknown origin were found with any residents that may be indicative of abuse... I [DON] did not find any evidence of substation of any physical abuse as originally reported to me. I [DON] did find that evidence exists of inappropriate language and statements towards the memory care residents on the first floor not in keeping with the core values of St. Mary's Care center..." When interviewed on 8/21/13 at 9:20 .m. the administrator stated the incident regarding R35 had been reported to OHFC and police called, but they didn't come out stating a crime had not been committed. The administrator verified RN-C should have "immediately" reported the incident, but it was reported by the DON to the state agency on 6/20/12, two days after the alleged incident. R53 made allegations of physical and verbal abuse which was not reported immediately to the state agency and investigated as directed by the facility policy.	F 226		

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F 226	Continued From page 30 R53's diagnoses included left hemiplegia [paralysis], personality disorder, and chronic pain. The quarterly MDS dated 8/6/13, indicated R53 was cognitively intact and required extensive assist for all ADL's except eating. When interviewed on 8/20/13, at 9:50 a.m. R53 stated a trained medication aide (TMA)-C, was rude and "mouthy" with me as well as "physical." R53 stated she had called for her insulin and TMA-C told her to "be patient." Then TMA-C assisted her into her wheel chair with a mechanical lift. While tucking the sling into her wheel chair, TMA-C had scratched her skin with her rings and fingernails. R53 had reported this to RN-B. When TMA-C returned, she stated, "You little rat, why did you tell on me." R53 then asked RN-B to not allow TMA-C to care for her any more. RN-B replied, "Well, if we don't have [TMA-C] help you, there may not be anyone to help you." R53 could not recall when this incident occurred, but TMA-C continues to care for her. When interviewed on 8/21/13, at 1:44 p.m. the social service director (SS)-C stated she knew R53 and TMA had "head butting," but was not aware of an exact accusation. She had not interviewed R53 to find out what this "head butting" was all about. The incident had been reported to SS-C by the surveyor at this time. When interviewed on 8/21/13, at 2:11 p.m. RN-B stated R53 never reported to her she did not want TMA-C to care for her. She was not aware of the incident described by R53 until today. When interviewed on 8/22/13, at 1:25 p.m. the director of nursing (DON) stated she was not aware of the R53's accusation of	F 226		

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F 226	Continued From page 31 verbal and physical abuse and did not know of any request for TMA-C to not work with her. DON stated if she had known, she would have accommodated R53's request. When interviewed on 8/22/13, at 2:07 p.m., SS-C stated she was not aware of the accusation until "yesterday" and stated as of today "she did not do anything and nothing had been reported." SS-C had not investigated or reported these allegations of verbal and physical abuse despite having knowledge of the incident on 8/21/13. When interviewed on 8/23/13, at 9:05 a.m. the administrator stated she knew nothing of R53's allegations until yesterday. She had not reported it to the state agency or started an investigation. Although R53's accusation of verbal and physical abuse had been reported to staff on 8/21/13, at 1:44 p.m. the facility did not immediately investigate or report the allegation as directed by the facility policy.	F 226	F 244 The facility does listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Care plans for residents R53, R12, R5, and R2 have all been updated to reflect current preferences for care to facilitate anticipation of care needs and prevent call light concerns. All staff will be educated regarding the expectations surrounding call light times and not turning off call lights until the need has been fully met and facility concern/complaint process by 10/15/13. All residents are identified at risk as the facility resident council represents all residents. The Policy and procedure for resident council has been updated	
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt responses related	F 244		

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F 244	Continued From page 32 to grievances of staffing concerns for 4 of 6 monthly resident council meeting minutes (March 2013, April 2013, July 2013 and August 2013) for 4 of 4 residents (R53, R12, R5, R2) who complained of staffing concerns. Findings include: Review of resident council meeting minutes dated 03/11/13, nursing section of the minutes revealed concerns, "director of nursing [DON] will talk to [R53] following the council meeting per [R53's] request. The facility's Departmental Response sheet, completed by the DON indicated, "Followed up [with] [R53]. Nothing to report to the council regarding issues [with] staffing, work in progress!" The resident council meeting minutes dated 04/08/13, administration section of the minutes revealed concerns, "[Administrator] reviewed staffing, explaining how the hours work and answering call lights in an appropriate timely manner." Nursing section of the minutes revealed concerns, "When census is low groups are spread out, which may reflect call light concerns." The facilities Departmental Response sheet, completed by the DON indicated, "[No] f/u [follow up]." Review of resident council meeting minutes dated 07/08/13, nursing section of the minutes revealed concerns, "[DON] was not present at the meeting. [R12] asked how long he should have to wait for someone to assist him. He stated he waited too long one evening. [Administrator] will meet with [R12] following the meeting for follow up. The facility's Departmental Response sheet completed by the Administrator indicated, "F/u	F 244	and TR and Social Service, and Management staff has been retrained to the updated policy and procedure. Council minute's document has been updated to clearly reflect grievances/concerns and resident council concerns will be entered into the facility concern database with follow up on concerns to be completed by the manager for the identified department. TR Director or designee will bring all resolved concerns to the next resident council to share with council members. All resident council concerns will be brought to the Quality Assurance (QA) meeting each month and monitored for completeness and patterns. The Administrator will monitor the on-going compliance. Completion Date: October 15th, 2013	

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F 244	Continued From page 33 [follow up] [with] one concern. [No] business to bring forward." Review of resident council meeting minutes dated, 08/05/13, nursing section of the minutes revealed concerns, "[R5] asked why it is taking 45 to 50 minutes to have call light answered and that she shouldn't have to sit on the commode for that long. States it is hard to get help when needed. Reminded residents that we are staffed accordingly, but that some residents require more than one person to assist them which can take a little longer if they are also assisting others." The facility's Departmental Response sheet completed by the DON indicated, "discussed [with] [R5] concern re: [regarding] call lights." R2, who attended all four of the council meetings, was interviewed on 8/23/13, at 1:30 p.m. R2 stated, "They [the staff] listen but I don't know if they do anything." R2 stated staff would come into rooms to turn of the call light and then leave without providing the care. "Some [staff] are good but some are not." R2 stated other residents in the facility were coming to her to voice concerns regarding staffing but declined to share any of these residents' names. During interview on 8/23/13, at 2:20 p.m. the activity director (AD) confirmed staffing concerns have been brought up several times by certain residents, at the resident council meeting, but felt nursing and administration had answered questions for specific residents. The AD stated, at each resident council meeting the department heads attend and can respond to any resident concern on the spot and they also complete the response sheet with any follow up answers to concerns. This is then reviewed at the following	F 244		

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F 244	Continued From page 34 resident council meeting. Although resident council participants voiced their grievances to the facility regarding staffing issues, the facility failed to respond and/or act on the resident council's concerns promptly and continues to be a concern.	F 244	F 246 The facility does ensure that residents have the right to resident and receive services in the facility with reasonable accommodations of individual needs and preferences.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate the needs of 1 of 1 residents (R4) who could not access his side of the room. Finding include: R4's diagnoses included dementia and a stroke. The quarterly Minimum Data Set (MDS) dated 06/11/13, identified R4 with moderately impaired cognition, and needing extensive assistance from staff with all of his activities of daily living (ADL's) except eating. R4's care plan dated 07/26/13, included, "[R4] is at risk for falls related to impaired balance and poor safety awareness/judgement. Resident does attempt to self transfer at times... keep pathways free of	F 246	R4's room was rearranged to accommodate equipment and personal items on 8/16/13. The facility will conduct audits of resident rooms and interview residents regarding accommodation of needs as well as audits of resident concerns. Audits will be conducted a minimum of three residents per week for one month and one resident per week from each floor (2 total residents) monthly for a period of six months. Facility customer concern/complaint process including concerns regarding room layout and roommate concerns will be reviewed with all staff by 10/15/13.	

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F 246	Continued From page 35 clutter..." During initial tour of the facility on 8/19/13, at 12:55 p.m.- 2:00 p.m. R4 was observed having difficulty getting into their room from hallway. There was a mechanical patient lift in the way, along with the placement of his roommate's bed. When interviewed on 8/20/13, at 10:30 a.m. R4 was sitting in his wheelchair outside of room in hallway. R4 was upset and stated, "I can't get into my room it is blocked... roommate just came back from the hospital [few days ago] and now they [staff] have a lot of equipment in the room." R4's room was observed and the following was present: one front wheeled walker, one wheelchair, sitting chair, two silver walkers folded up leaning against wall, and two commodes at the end of the roommate's bed. All of this all equipment was in the only pathway to R4's side of the room and bed, making it difficult for R4 to independently get to his side of the room. When interviewed on 8/23/13, at 3:30 p.m. licensed practical nurse (LPN)-C stated R4 needs assistance of two staff, and verified R4 and his roommate's room does get "crowded with all of the equipment," and will often need to rearrange equipment to get R4 in and out of his side of the room which has been an ongoing problem. Even though the facility was aware R4 had trouble getting into his room due to multiple equipment, the facility failed to ensure R4 had a clear pathway to access his own room.	F 246	Results of audits will be brought to the Quality Assurance (QA) each month. DON/Designee will monitor /review audits to ensure on-going compliance. Completion Date: October 15th, 2013.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 36 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R61) reviewed for pain, had an effective ongoing pain management program. Findings include: R61's diagnosis included generalized pain and was receiving comfort cares. The quarterly Minimum Data Set (MDS) dated 5/11/13, indicated R61 was cognitively intact, required extensive assistance with activities of daily living (ADL's), did not receive any scheduled pain medication, had received PRN (as needed) pain medication and rated pain at a "7" on a 0-10 pain scale (with zero being no pain to 10 being the worst pain experienced). R61's previous quarterly MDS dated 2/11/13 indicated she was not having any pain. R61 was observed on 8/21/13, at 10:15 a.m. propelling herself in her wheelchair independently going outdoors. The resident appeared comfortable, and did not have any difficulty maneuvering herself with the wheelchair to go outdoors.	F 309	F 309 The facility does ensure that residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with a comprehensive assessment and plan of care. R61 had new pain assessment completed on 9/9/13. R 61 was seen by primary care physician on 9/9/13. R 61's pain management regimen was changed by the primary care physician on 9/9/13. The facility will conduct random audits of pain management assessments completion coordinated with care plans via IDT utilizing ARD schedule and auditing will include a minimum of three residents per week for one month and then a minimum of one resident monthly for six months. The facility pain management policy was updated to reflect	

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F 309	Continued From page 37 R61's physician orders dated May 2013, identified the following PRN pain medications were available for use: - Tylenol (analgesic) 650 mg [milligrams] as needed for pain for a pain rating of 1-3. The prescription start date was 10/30/12. - Norco (hydrocodone-acetaminophen tablet narcotic) 5-325 mg. One tablet for pain rating of 4-5, two tablets for pain rating of 6-10 every 6 hours. The prescription start date was 10/30/12. Review of R61's Progress Notes revealed the following: 7/1/13- Doctor had seen resident. "Resident informed doctor about her back pain. Resident stated that her pain medication relieves her back pain." 8/5/13- "Complained lower back pain and insomnia related to back pain. Gave Norco x1 at 11:00 p.m. with no further complaints." 8/9/13- "Resident complained of left elbow pain on inner side and was painful to touch. Gave resident 2 PRN Norco. This was effective." This was the first documentation of R61 having pain in her arm. 8/15/13- "Therapy: visited with resident for follow up regarding residents statement ... she dislikes her wheelchair cushion as well as nursing reports elbow pain. When asked about her elbow pain, resident help [sic] up right elbow (had complained of left elbow pain to nursing) and then winced and cried out in pain stating, 'my elbow is fine its my shoulder!' Writer removed clothing from right shoulder and noted a robins egg-sized lump very light pink in color on the top of the shoulder. It was very tender to very light palpation. Writer	F 309	appropriate assessments. All licensed staff will be re-educated to this policy by October 4, 2013. Audit results will be reviewed at Quality Assurance (QA) meetings each month. DON/Designee will monitor for on-going compliance. Completion Date: October 4, 2013.	

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F 309	Continued From page 38 notified nurse manager of lump. No apparent pain observed by writer or reported by patient in any body parts other then right shoulder during visit. 8/15/13- "Complained pain to left shoulder. 9/10 with palpation to top of left shoulder, very minimal swelling. ROM is WNL, no pain. Norco given and effective." R61 received Norco twice on 8/15/13; both times for left shoulder pain. 8/16/13- "ROM done to right shoulder without resistance or discomfort. No swelling noted on right shoulder." This progress note did not address the left shoulder. R61 received Norco twice on 8/16/13, both times for a pain rating of 10/10, however, there is no indication of the location of the pain. 8/17/13- "Rated pain a 0/10 when right shoulder not touched, 10/10 with palpation." The facility was charting on right shoulder. According to the MAR, the resident did not take any PRN pain medication on 8/17/13. However, in the Narcotic count book, the facility charted a Norco was removed for R61 on 8/17/13 at 2022 (8:22 p.m.). There was no corresponding charting regarding the administration of the Norco to R61, and if it was effective or not. 8/19/13- "Stated that right shoulder felt pretty good and refused pain medications." However, on the residents Medication Administration record (MAR) R61 received Norco at approximately 9:36 p.m. There was no charting regarding what the pain medication was given for, pain rating, or how many Norco were given and if it was effective. Review of R61's Medication Administration Record (MAR), R61 received the following PRN pain medications: August 1-August 22, 2013- Norco was taken 24	F 309		

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F 309	Continued From page 39	F 309		

times, and Tylenol was taken one time. The reason for the pain medication was "pain, sleep, pain all over, legs, and left shoulder." The intensity of the pain was only documented on 8/4/13 at a "8", and on 8/16/13 at a "10." On 8/16/13 the resident received Norco for "pain" twice at 2:39 p.m. and again 9:15 p.m. rating it at a 10. Although the resident began to use the PRN pain medication more frequently in August 2013, there was no indicated the current pain regimen was effective for R61's pain management.

July 2013- Norco was taken 21 times and Tylenol was taken 9 times. On the MAR there was no way to determine if the resident received one or two Norco for pain. The "reason" for the pain was back or hip pain and the only day the intensity was charted was on 7/27/13 at a "4." The follow up results were documented as the pain medication was "effective" for the pain.

June 2013- Norco was received 25 times for pain. On the MAR there was no way to determine if the resident received one or two Norco for pain. The "reason" for the pain was back pain or leg pain. The facility did not always chart the intensity of the pain, but on 6/14/13 it was charted at a 10/10 in lower back, 6/16/13 a 10/10 lower back. Tylenol was not used during June 2013. The follow up results were documented as the pain medication was "effective" for the pain.

R61's care plan dated 5/10/13, identified pain related to osteoarthritis and had decreased range of motion to bilateral lower extremities due to pain. Resident complained of back pain and was encouraged to ambulate more and reduce amount of time spent in bed. Staff were directed

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F 309	Continued From page 40 to monitor for pain on every shift, medicate for pain per doctors orders, notify doctor of worsening, new, or unrelieved pain, encourage to get out of bed, and Advil 200 mg every 6 hours as needed. Although the care plan identified R61 could have Advil for pain, there was no physician order for this, nor was this identified on the medication administration record (MAR) dated August 2013. There were no scheduled pain medication for R61, only as needed pain medications. R61's pain assessment dated 5/19/13, identified a resident interview had been completed regarding pain experienced in the prior five days to the assessment period. R61 stated she had received PRN pain medication for pain, experienced pain occasionally with an intensity of "4" which had not effected the day-to-day activities or made it difficult to sleep at night. The pain assessment summary completed by the facility indicated resident "states has leg aches. Receives Norco PRN, which she states is effective." R61's most current pain assessment completed on 8/16/13, identified a resident interview had been completed regarding pain experienced in the prior 5 days to the assessment period. R61 stated she had received PRN pain medication for pain, experienced "very severe, horrible" occasional pain with an intensity of a "10" which had not effected daily activities but had made it hard to sleep at night. The pain assessment summary indicated "Occasional right shoulder pain 10/10. States pain increases with movement or palpation. States no pain at rest. States hard to sleep due to prefers to lay on that side.	F 309		

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F 309	Continued From page 41 Refuses hot or cold pack. Norco somewhat helpful. Being evaluated by therapy." Although the increase in shoulder pain was new for R61, there was no indication the shoulder pain had been assessed to determine possible cause. There was no indication if the physician had been contacted regarding the Norco only being "somewhat helpful" in relieving the residents pain. During interview on 8/23/13, at 1:10 p.m. R61 stated she currently had no pain and was "comfortable." During interview on 8/23/13, at 4:05 p.m. with the Physical Therapist (PT) stated she had seen R61 briefly regarding a new wheelchair cushion but had not seen the resident for pain since June of 2013. When she had seen the resident for chronic back pain and had no complaints at that time. During interview on 8/23/13, at 5:00 p.m. the registered nurse (RN)-B stated R61's pain varies related to arthritis and the pain varies from her shoulder to her elbow to her back. She was not aware regarding the new onset of pain in the residents shoulder or the increase in PRN pain medication usage for August 2013. During interview on 8/23/13, at 5:05 p.m. RN-M stated the floor nurses should have followed up on R61's increase in pain and increase in PRN use. She verified they were not always charting regarding the pain location, level, or how many Norco tablets R61 received to alleviate her pain. During interview on 8/23/13, at 5:08 p.m. RN-G stated she completed R61's pain assessment on 8/16/13. She stated the resident had complained	F 309		

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F 309	Continued From page 42 of shoulder pain to her at that time, and she passed it on report to notify the physician and get an X-ray if the pain had not resolved. RN- G verified R61 had an increase in pain and had been using additional PRN medication for her pain. R61's pain should have been reassessed to determine a appropriate pain management program.	F 309	F323 The facility does ensure that the resident environment remains as free of accident hazards as is possible.	
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision to prevent elopement for 7 of 7 residents (R83, R60, R73, R32, R64, R40, and R68) that were identified at risk of elopement, which constituted an immediate jeopardy situation. In addition, the facility failed to ensure chemicals were secured on the secured memory care unit were not accessible to residents. This had the potential to affect 7 of 7 residents (R83, R60, R73, R32, R64, R40, and R68) who wandered independently on the first floor secured unit. The immediate jeopardy began on March 29,	F 323	R83 care sheet was updated to reflect the use of the Roam Alert Tag and its location. R83 care plan was updated to reflect the use of the Roam Alert Tag on 9/16/13, the location of the tag and the need to verify the function of the Tag daily. The tag placement and function is checked daily. The elopement assessment was updated for R83 on 8/21/13. R60 The elopement assessment was updated for R60 on 8/21/13. Wanderguard was discontinued due to assessment. Care plan updated. R73 care sheet was updated to reflect the use of the Roam Alert Tag and its location on 8/27/13 R73 care plan was updated to reflect the use of the Roam Alert	

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F 323	Continued From page 43 2013 due to the facility's systemic failure of their WanderGuard system to function properly, inadequately monitoring of the WanderGuard door system, and proper closure of the door to prevent elopement placed seven residents the facility identified as elopement risks at immediate jeopardy, to their health and safety. The administrator and the director of nursing (DON) were notified on 8/21/13, at 5:10 p.m. of the immediate jeopardy to the health and safety of the residents at a pattern level (K). The IJ was removed on 8/23/13 at 9:11 a.m. but remained at the lower scope and severity at an E level, pattern with no actual harm. Findings include: R83 was assessed by the facility as a high risk for elopement risk, and was placed on the secured memory care unit. However, the facility's WanderGuard system was not functioning properly, nor was there proper closure of the first floor stairwell door to prevent elopement. R83 eloped from the secured memory care unit prior to 4/28/13 (date uncertain) and on 4/28/13 was found outside the facility without staff knowledge. R83 had diagnoses of frontotemporal dementia, agitation and depression. R83's most recent quarterly Minimum Data Set dated 5/22/13 indicated he was cognitively intact, ambulated independently and had wandering behavior one to three days. R83's care plan dated 2/26/13 indicated his cognitive function varies throughout the day. The plan of care indicated "he is at risk for elopement as he was wandering from home previously."	F 323	Tag, the location of the tag and the need to verify the function of the Tag daily. The tag placement and function is checked daily. R32 The elopement assessment was updated for R32 on 8/21/13. Resident was not found to need WanderGuard placement. Care plan updated. R64 care sheet was updated to reflect the use of the Roam Alert Tag and its location on 9/16/13. R64 care plan was updated to reflect the use of the Roam Alert Tag, the location of the tag and the need to verify the function of the Tag daily. The tag placement and function is checked daily. The elopement assessment was updated for R64 on 8/19/13. R40 elopement assessment was updated on 8/21/13. Family declined the placement of the wander guard monitoring bracelet and the roam alert system. Care plan updated with specific approaches on 8/21/13.	

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F 323	Continued From page 44 The plan of care directed staff to monitor and assess R83 for elopement, provide supervision off the unit and monitor "whereabouts Q [every] 30 minutes." The care plan further indicated R83 had a WanderGuard bracelet to his left wrist to alert staff if he left the facility. The nursing assistant Resident Care Sheet undated indicated he does not have a WanderGuard bracelet. R83's Elopement Risk Assessment dated 2/14/13 indicated he had elopement successes in the past, wandering with no rational purpose and attempted to open doors. The assessment also indicated he has a WanderGuard bracelet and was at high risk for elopement. R83 was observed on 8/19/13, at 3:25 p.m. wandering up and down the hallway twice, then went into his room and laid on his bed. At 6:08 p.m. R83 had eaten dinner, walked back to his room. At 7:21 p.m. he had wandered up and down the hallway until staff offered him a snack, then sat in the day room and ate it. On 8/23/13, at 1:50 p.m. R83 was observed ambulating in the hallway on the memory care unit wearing only his underwear and socks. There was no staff around in the hallway or day room. On 8/23/13 at 2:00 p.m., the administrator stated R83 walks up and down the halls but does not attempt to leave the secured memory care unit. Review of the facility Vulnerable Adult (VA) Report dated 4/28/13 indicated "visitors on the first floor memory care locked unit, family of another resident. [R83]was found by the memory care nurse while on her break on the sidewalk outside	F 323	**IJ Abatement plan of correction:** The facility has updated the abuse and prevention plan with the state of Minnesota definition of for elopement. All staff of St. Mary's Care Center will receive training regarding the new policy and procedure to be completed by August 22, 2013 at 1 PM. The facility has created a WanderGuard placement algorithm to ensure the appropriate placement of WanderGuard braclets for those residents at risk of elopement. All management and nursing staff will receive training on the new algorithm to be completed by August 22, 2013 at 1 PM. The code purple protocol has been updated to ensure proper response in the event of a missing resident. The updated protocol will be trained to all staff by August 22, 2013 at 1 PM. The facility has created a WanderGuard System policy to	

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F 323	Continued From page 45 of the facility unharmed, looking for the [library]." The VA report indicated the alarm had not reset when R83 followed the visitors up and out the doors. The administrator was immediately notified of the elopement incident. The VA investigative report dated 5/1/13 indicated he was independent with ambulation and needed a secured unit due to his dementia. The investigation identified that several visitors were in the building during the time including two children between 8-10 years old as possible suspects of allowing R83 to get onto the elevator and leave the building. The VA Report further indicated the facility "...counseled the parents and children..." who they felt were involved in R83's elopement by the nurse to make sure they kept residents secure and safe. During interview on 8/21/13 at 9:22 a.m. the health unit coordinator (HUC)-A stated approximately six months ago (prior to the 4/28/13) incident, unsure of the date, R83 had went through the first floor secure door, behind the custodian (C)-A and was seen through the second floor door window in the stairwell. HUC-A told C-A immediately that R83 was behind him. The HUC-A stated, the stairwell between first and second floor does not have an WanderGuard system. Review of the medical record did not identify, R83 was found in the stairwell, off the secured memory care unit, by C-A and HUC-A. Stairwell Door: During the initial tour of the facility on 8/19/13, at 1:35 p.m. the stair well door in the secured memory care unit, leading to the second floor,	F 323	assure the responsiveness of the system and staff. All staff will be trained on the new policy by August 22, 2013 at 1 PM. The process for monitoring the WanderGuard system has been amended. The Director of Plant Operations will monitor the WanderGuard system per the monitoring policy. All management and plant operations staff will be educated on the amended policy by August 22nd at 1 PM. The facility does have records that door checks have been completed on the secure memory care unit. These records will be provided by the Director of Plant Operations on August 22, 2013. The facility VA reporting action plan protocol has been amended to ensure appropriate responses to all VA situations. Action plans will be implemented in step 7: respond of the abuse prevention plan. All staff will be trained regarding the new	

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F 323	Continued From page 46 was opened without the use of the security code. During observation on 8/19/13, at 3:20 p.m. the stair well door, on the secured memory care unit, that led to the second floor was opened and allowed to shut on its own with a self closure on the door frame. After the door was shut for 15 seconds, the secured door was easily opened without the use of the security code to open the door. At 5:01 p.m. the same stair well door as previously opened, on the secured memory care unit, was again opened and allowed to shut on its own. After it was shut for 15 seconds, the door was again easily opened without the use of the security code. During observation on 8/19/13, at 7:40 p.m. the stair well door in the secured memory care unit, was opened and allowed to shut on its own. After it was shut for 15 seconds, the door was easily opened without the use of the security code. During observation on 8/21/13, at 2:44 p.m. the stair well door in the secured memory care unit, was opened and allowed to shut on its own. After it was shut for 15 seconds, the door was easily opened without the use of the security code. During observation on 8/22/13, at 9:40 a.m. the stair well door in the secured memory care unit, was opened and allowed to shut on its own. After it was shut for 15 seconds, the door was easily opened without the use of the security code. During interview on 8/21/13, at 9:55 a.m. C-A stated there was an incident in the stairway, several months ago, unsure of date. He was going up the stairway and the door did not latch behind him on the first floor secured memory unit	F 323	policy by August 22, 2013 at 1 PM. The facility will continue to having the nursing department check the functioning of the WanderGuard bracelets each day and document the function in the MAR/TAR electronically. The facility has created a process and procedure for daily checks of the WanderGuard system to be completed by the nursing department as per the manufactures protocols. Checks will be documented on a log to be maintained by the nursing department. All RN, LPN, and TMA staff will be trained on the process and procedure by August 22, 2013 at 1 PM. The facility has updated the abuse and prevention plan [redacted] All staff of St. Mary's Care Center will receive training regarding the new policy and procedure to be completed by August 22, 2013 at 3 PM.	

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

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F 323	Continued From page 47 and R83 followed him up the stairwell. "It scared the living heck out of me, he was right behind me, every time I look now." On 8/21/13, at 11:00 a.m. the administrator stated she was aware of the elopement on 4/28/13 but was not informed that R83 had eloped from the secured memory care unit in the stairwell and should have been notified. During a tour of the secured memory care unit on 8/21/13, at 11:11 a.m. the maintenance technician (MT)-A, stated the stairwell door takes approximately three seconds to re-lock after it closes. He was unaware at times the door did not close completely, and re-locked to prevent residents from the secured unit from entering the stairwell. During interview on 8/21/13, at 11:30 a.m., the maintenance technician (MT)-A stated the facility had suspected a family members children were inputting the code by the elevator to release the elevator to go up to the second floor and allowed R83 to get into the elevator. There was also a separate code only staff know, which prevents the residents WanderGuard bracelet from sounding when they entered the elevator, so they can transport them to medical appointments or family outings. The children would not have known this code, so the WanderGuard system should have alarmed. The MT-A further stated they have been having problems with the wall alarms for the WanderGuards so they had contacted the company who came out in March 2013 to look at the WanderGuard system. The facility was having problems with the system making a chirping sound. The company came out, and we	F 323	WanderGuard system testing will occur in the following fashion: Weekly by the Director of Plant Operations and results documented in the computerized maintenance system. Equipment tested will be verifying the monitor operation (door locations). Procedure to be used to check the system is the Monitoring Systems for the WanderGuard System, Alarm System, Exit Doors, and Stairwell Doors. Daily the nursing department will test the bracelet functioning of all residents with WanderGuards on their persons. This will be documented in the electronic medication record. Procedure to be used is the bracelet testing procedure the testing of the WanderGuard System Door and Bracelet Check Policy. Daily the nursing department will test the monitor operation of the WanderGuard system (door locations) and record the results of	

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F 323	Continued From page 48 found out when there is too much radio frequencies it interfered with the WanderGuard system. The MT-A stated last night (8/20/13) he was called by the nursing staff due to the WanderGuard system made a chirping sound and he had the nurse deactivate the wall alarm and turn on a sensor alarm which is a back up system for the elevator. Prior to last night he had not been called for any issues with the WanderGuard system since March 2013. The MT-A stated he does not check the WanderGuard door units, the evening nurses check them daily. During interview on 8/21/13, at 2:20 p.m. the evening supervisor, licensed practical nurse (LPN)-B stated she works the afternoon shift, (2:00-10:30 p.m.) and has never checked the WanderGuard system to ensure it was functioning properly or had ever been directed to complete this task. During a telephone interview on 8/21/13, at 3:10 p.m. the night supervisor, registered nurse (RN)-C, stated she has a check list of night shift extra duties that she keeps for herself, the facility does not provide her with any check list. Her list included stocking, cleaning various items and checking to ensure all exit doors are locked. The list did not include checking the facility WanderGuard system at the doorways or elevator to ensure it was functioning properly. RN-C stated last night the WanderGuard system in the secured memory care unit at the elevator was making a "screeching" noise. She had not checked the door with the WanderGuard tester to ensure it was functioning properly. Instead, she called maintenance and they told trained medication aide (TMA)-A who was working in the secured memory care unit what to do to fix the	F 323	the checks will be documented on the daily exit check log. Procedure to be used is the universal tested procedure in the testing of the WanderGuard System Door and Bracelet Check Policy. The Plant Operations Director will check the stairwell doors each week using the procedures in the Monitoring Systems for the WanderGuard System, Alarm System, Exit Doors, and Stairwell Doors. Results will be documented in the computerized maintenance system. All elopement assessments and care plans have been updated for the seven (7) identified residents of: [redacted] with individual approaches for each resident. Daily the nursing department will test the bracelet functioning of all residents with WanderGuards on their persons. This will be	

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F 323	Continued From page 49 problem by using a screw driver. She was not sure what the malfunction of the WanderGuard system was. Review of Facility Visit Report from Stanley Health Care who came to fix the WanderGuard system dated 3/29/13, indicated, "Site has poor range on lower level elevator door, excessive Electromagnetic Interference [EMI]. I tried replacing main controller unit, main antenna and aux antenna, no configuration improved the range. I walked with maintenance and we shut off elevator control and immediate circuit panel no visible audible change. I was able to get slight improvement by rotating main antenna by ninety degrees but still less than satisfactory. Site has EMI which is causing issues, not able to track down at this time. Site may also try to relocate main/aux antenna but noise is throughout the area..." During telephone interview on 8/22/13, at 12:22 p.m. with Stanley Health Care representative-A stated she had spoken with the technician that was out to the facility on 3/29/13 and he was unable to fix the problem due to all of there EMI. The EMI's can cause false alarms or prevent the unit from working at all. The representative also stated EMI can be caused from a truck parked out side with a two way radio, the facility's two way radio the staff use, humidity and many other reasons. The only way the facility could fix the problem is if they replace the unit they have. There was no indication that further changes or upgrades had been completed to the WanderGuard system, since the 3/29/13 visit from Stanley Health Care, even though the	F 323	documented in the electronic medication record. Procedure to be used is the bracelet testing procedure the testing of the WanderGuard System Door and Bracelet Check Policy. The Plant Operations Director will adjust the door closer located on the stairwell door to ensure the door properly closes by August 22, 2013 at 3 PM. Daily the nursing department will test the monitor operation of the WanderGuard system (door locations) and record the results of the checks will be documented on the daily exit check log. Locations that will be checked will be the elevator door and the north door on first floor. Procedure to be used is the universal tested procedure in the testing of the WanderGuard System Door and Bracelet Check Policy. The checks will occur each shift. The Plant Operations Director will adjust the door closer located on the stairwell door to ensure the	

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F 323	Continued From page 50 system continued to have excessive EMI, causing the system to potentially malfunction. Review of the manufacturer's guidelines, Manual WanderGuard E series departure alert system undated identified, "The WanderGuard E series departure alert system is designed to be virtually trouble-free and easy to maintain. However, as with any electronic equipment, the WanderGuard E system is not foolproof. Components may fail without warning or be damaged, signaling devices may be taken off, and electromagnetic interference (EMI) may occur. In fact, EMI is common in most environments and can be generated by other electronic equipment in the facility. Sometimes the EMI noise generated is high enough that the operation of the WanderGuard E system-and any other device using radio frequencies could be affected..." The manual also indicated EMI can come from a number of sources: digital phone systems, fire alarm systems, lines from remote annunciators, computers, copiers, printers, televisions, existing power lines, high-power dimmer switches, floor buffers, commercial vacuum cleaners and electronic ballasts in fluorescent lighting. The manufacturer's manual indicated on page 31 to "Test the WanderGuard E plus departure alert system regularly. Do not rely exclusively on WanderGuard E Plus built-in self tests to indicate the WanderGuard E Plus system is working properly. Test door modules weekly on each shift with surrounding power devices turned on. Record the result. Test signaling devices daily as detailed in the signaling device instructions and the WanderGuard E series User Manual." During interview on 8/22/13, 2:30 p.m. the	F 323	door properly closes by August 22, 2013 at 3 PM. The Administrator will monitor the processes for on-going compliance. Facility replaced the Wanderguard system with the Roam Alert system on August 27th, 2013. The stairwell door received a Roam Alert system coverage on August 28th, 2013. The Roam Alert system (doors, elevator, and stairwell) is monitored by nursing staff daily and recorded on the log form kept at the nursing station. The Roam Alert Tags are monitored for placement and function on a daily basis by the nursing staff and recorded in the residents' Electronic Treatment Record. The Maintenance department tests all system doors weekly and records results of tests in the computerized TELS system.	

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F 323	Continued From page 51 administrator stated she was aware of R83 eloping from the facility in April 2013, felt some children were playing on the elevator and R83 had gotten out of the facility using the elevator to get to the second floor. She was aware of the WanderGuard system not functioning properly in March 2013 but was not aware the system could be replaced to eliminate the problems with EMI. During interview on 8/21/13, at 9:24 a.m. LPN-A stated R83 had eloped once from the facility a few month ago. She had been working at the time of the elopement. Some kids were playing in the elevator and R83 had gotten outside the building without staff knowledge. After this occurrence, the facility posted a picture of R83 in the stairwell, with a notice to not to let R83 follow you up the stairs. When interviewed on 8/21/13, at 9:28 a.m. nursing assistant (NA)-A stated R83 had gotten out of the building once, and now they have to make sure the secure, locking stairwell door by the elevator shuts behind them, because it does not always latch. During interview on 8/21/13, at 9:33 a.m. NA-B stated she did not recall anyone actually getting out of the locked unit. All staff know to check and make sure the door shuts behind you when opening the stair well door, because it does not always latch. When interviewed on 8/21/13, at 1:40 p.m. the social worker (SW)-A stated there was nothing in the admission process they provided to newly admitted residents or families regarding the code for the doors and elevators. She stated the code	F 323	All staff was educated to the policies and procedures for the Roam Alert system by 9/1/13. The Roam Alert process is included on the nursing assistant and licensed staff orientation checklist as of 9/13/13. Chemicals were removed from patient areas and secured on 8/23/13 all areas were additionally checked for unsecured chemicals on 8/23/13. All staff will be re-educated regarding chemical storage policy and procedure by 10/7/13. System and Tag checks will be audit monthly by the DON and Maintenance Director. DON/Designee will audit the storage of chemicals through monthly safety rounds. Results of the audits will be brought to the Quality Assurance (QA) meeting monthly. Administrator will monitor for on-going compliance.	

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F 323	Continued From page 52 is posted on the upper floor by the door to the stairwell and was not posted in the lower floor, secured memory care unit. There is no system to inform newly admitted residents or family members the need to ensure no one follows them out of the secured memory care unit. When interviewed on 8/21/13, at 2:05 p.m. RN-A (secured memory care unit manager) stated, when residents are first admitted to the secured memory care unit, they are assessed for risk of elopement by social services. If they are at risk, an ankle or wrist WanderGuard bracelet is placed on the resident. The bracelet is to be checked by the LPN, or TMA, who is assigned to the unit, every shift for placement as well as function. A device is kept on the medication cart for this purpose and it checks the battery function of the WanderGuard bracelet. The entire bracelet is replaced every three months. If the daily checks indicate the WanderGuard bracelet is no longer functioning, it would be replaced immediately. RN-A stated the night shift has a check list of duties that would include checking the function of the doorway, and elevator WanderGuard system. RN-A was unable to find this check list. RN-A had not known the stairwell door did not always latch, or that it could be opened without punching in the code, as she had never attempted to open it without the code. When interviewed on 8/21/13, at 2:18 p.m. TMA-B stated she works both days and evenings, and checks the individual resident WanderGuard system for functioning every evening, but had never checked the function of the elevator for the WanderGuard system, nor had ever been instructed to do so. She also had never checked the stairwell door to ensure it latched when it	F 323	Correction Date: October 7, 2013.	

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F 323	Continued From page 53 closed. During a telephone interview on 8/21/13, at 3:30 p.m. TMA-A stated she works the night shift on the secured memory care unit and there are usually 4-5 residents up at any given time during the night, who wander about. TMA-A stated they have a hard time "keeping an eye on them." She stated they never check the WanderGuard system on the exit doors or elevator for proper functioning on the night shift. Although the facility was aware of R83's elopement out of the facility on 4/28/13 and had attempted to leave the facility through the stairwell approximately six months earlier, before 4/28/13 event, the WanderGuard system nor the secured stairwell door was functioning properly. During interview on 8/21/13, at 12:00 p.m. the DON stated R60, R73, R32, R64, R40, and R68 were placed on a elopement risk watch according to their elopement risk assessment that they complete upon admission and review quarterly. R60 was assessed by the facility as a high/moderate risk for elopement and was placed on the secured memory care unit. However, the facility failed to ensure exit doors, stairwells, and elevators were secured. R60's diagnoses included Alzheimer's disease and psychotic disorder. The quarterly MDS dated 7/12/13, identified severe cognitive impairment, required extensive assistance with ADL's, and had not wandered during the assessment period.	F 323		

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F 323	Continued From page 54 The Cognitive Loss/Dementia CAA dated 1/10/13, included; "Will frequently attempt self transfers and begin walking without assist. Is an elopement risk which [sic] wears a WanderGuard for safety." The elopement risk assessment dated 1/7/13 identified R60 was at moderate risk for elopement. R60's care plan dated 7/16/13, included; "Resident is here on first floor for long term care. Previously living with husband and attending Adult Day program but husband was no longer able to assist. Residents mood does fluctuate throughout the day, especially after family/husband leave as she does want to go with them. Elopement risk high at this time and WanderGuard system in place." R60's progress notes include the following: 8/10/13 at 2:25 p.m. "Up per self x [times] 2 found by elevator BR [bathroom]...mumbles under her breath, 'They are going to kill me' get me out of here." 8/2/13 at 10:31 p.m. "...Did make the comments 'I want to get out of here' and 'I hate it here' this afternoon before dinner. Attempted to self transfer a couple times, walked down the hallway to her room and back to lounge..." 7/28/13 at 2:06 p.m. "Self transferred x [times] 3 walker to DR [dining room], wanting to go home..." During interview on 8/22/13, at 4:40 p.m. RN-A stated R60 remained a high risk for elopement, but had not made any attempts to leave the facility.	F 323		

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F 323	Continued From page 55 R73 was at moderate risk for elopement and was moved to the secure memory care unit on 8/16/13, and had a WanderGuard bracelet to alert staff of when he attempted to elope. However, the facility failed to care plan this risk, failed to monitor the WanderGuard bracelet for continued function, and failed to ensure exits, stairwells, and elevators were secure. R73's diagnosis of Alzheimer's disease The admission MDS dated 7/18/13, indicated he was cognitively intact and had not wandered. The facility progress notes dated 8/13/13, identified R73 had recently declined in memory and had moderate cognitive impairment. R73's progress note dated 8/20/13, indicated, "Was transferred to first floor on 8/16/13 d/t [due to] elopement risk." R73's care plan last updated on 8/20/13 did not address the risk of elopement. R73's Elopement Risk Assessment dated 7/1/13, indicated R73 was at moderate risk of elopement. The risk assessment had not been updated after he was moved to the memory care unit on 8/16/13 due to his "elopement risk." R73's undated Resident Care Sheet, utilized by the nursing assistant (NA) indicated a WanderGuard was being used and was located on R73's left leg. Review of R73's physician order sheets, medication administration records, and treatment records, dated 6/1/13 through 8/20/13, failed to include any checking of R73's WanderGuard bracelet on his left leg to ensure if was present and functioning properly.	F 323		

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F 323	Continued From page 56	F 323		

When interviewed on 8/22/13, at 4:40 p.m. registered nurse (RN)-A stated R73 was brought to the memory care unit because he was trying to get out of the facility, he was a wander risk and unsafe to be out on his own. The facility keeps a book at the nurses station to easily identify residents at risk of elopement, but had not added R73 to this book yet.

R32 was assessed by the facility as an moderate elopement risk, and was placed on the secured memory care unit. However, the facility failed to ensure exit doors, stairwells, and elevators were secured.

R32's diagnosis included dementia. The quarterly MDS dated 5/2/13, indicated severe cognitive impairment and used a walker, or wheel chair for mobility. R32 had no wandering behavior identified during the assessment period.

R32's care plan updated 8/13/13, identified, "She is an elopement risk as she did eloped from her last facility." Staff were directed to monitor R32 for elopement and exit seeking but did not wear a WanderGuard unit.

R32's Elopement Risk Assessment dated 7/29/13, included R32 was at "moderate" elopement risk but did not identify what placed R32 at elopement risk, or what wandering behaviors R32 had exhibited.

During interview on 8/22/13, at 4:40 p.m. RN-A stated R32 was assessed as being an elopement risk because she had eloped from her previous facility. R32 had not made any attempts to elope

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F 323	Continued From page 57 since admission. RN-A stated they recently, no date given, re-assessed R32 and she was no longer considered an elopement risk. However, they had not performed a formal assessment, or updated the care plan. R64 was assessed by the facility to be an moderate elopement risk, and R64 was placed on the secured memory care unit and the facility failed to ensure security measures were in place to prevent an elopement. R64's diagnoses included dementia, mood disorder, anxiety and depression. The quarterly MDS dated 5/29/13, indicated he was moderately impaired in cognition and ambulated independently. R64 had no wandering behavior during the assessment period. R64's care plan dated 3/12/13, indicated R64 was "At risk for elopement related to dementia and alcohol abuse. Was found on facility grounds outside of building x [times] 2. Oriented to person only. Exit seeking frequently. Attempts to open door to courtyard to go out to smoke." The care plan also indicated he has a WanderGuard bracelet, to alert staff when she left the secure unit. R64's Elopement Risk Assessment dated 8/20/13 indicated he was a moderate elopement risk. The assessment also indicted he has alcohol induced dementia, in the past has attempted to elope, will also pack his bags and make statements about leaving. The assessment identified R64 had not recently attempted to exit seek and was redirectable.	F 323		

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F 323	Continued From page 58 During interview 8/23/13 at 2:05 p.m., the administrator stated that R64 was found on the facility grounds several years ago and that he has made no recent attempts to elope from the facility. R40 was assessed by the facility as an moderate elopement risk, R40 was placed on the secured memory care unit and the facility failed to ensure security measures were in place to prevent an elopement. R40's diagnoses included Alzheimer's disease and dementia. R40's quarterly MDS dated 7/12/13 indicated she was moderately cognitively impaired and transferred with set up assistance. The MDS also indicated R40 did not wander during the assessment period. R40's care plan dated 2/09/13 indicated she is on the memory care unit, she is no longer appropriate for previous arrangements as she was wandering late at night requiring a secured unit. The care plan also indicated her elopement risk was moderate due to leaving previous facility, but did not identify a WanderGuard bracelet was used. R40's Elopement Risk Assessment dated 4/5/13 indicated she was at moderate risk for elopement. The assessment also indicated had eloped in the past and repeatedly opens doors and shuts off alarms of secured unit and resisting redirection from staff. R68 was assessed by the facility as low risk for elopement and was placed on the secured	F 323		

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

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F 323	Continued From page 59 memory care unit and the facility failed to ensure security measures were in place to prevent an elopement. R68 had diagnosis which included dementia. R68's most recent quarterly MDS dated 5/16/13 indicated she was severely cognitively impaired and needed extensive assistance with transferring and mobility. R68's MDS also indicated she had not wandered during the assessment period. R68's current plan of care dated 2/22/13 indicated she is on the memory care unit and will remain as not appropriate at pervious home setting. The care plan also indicated she has a WanderGuard to her left wrist and staff to check daily. R68's Elopement Risk Assessment dated 2/8/13 indicated she was at a low elopement risk and had a diagnosis of dementia. During interview on 8/21/13 at 1:30 p.m., with the director of nursing (DON) stated that R68 has not attempted to leave the facility, but they placed her on elopement risk due to her Elopement Risk Assessment. When interviewed on 8/22/13, at 4:40 p.m. RN-A did not know how it was determined which residents wore WanderGuard bracelets and who does not. As some residents who wore a WanderGuard bracelet had been assessed as low risk, moderate risk, or high risk. There was no policy or procedure on determining who wears a WanderGuard bracelet. The facility Potential for Elopement Policy	F 323		

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F 323	Continued From page 60 undated indicated "Safety precautions are put into place to protect residents of St. Mary's Care Center to ensure supervision to prevent elopement and/or wandering to or in inappropriate settings." The policy further indicates staff are to immediately notify the Administrator, notify police officials, Notify OHFC/CEP, Notify family/responsible party... The elopement risk is reviewed quarterly and as needed with changes of condition. The facility policy lacked to include how they are checking to make sure the WanderGuard system is functioning according to manufacturer guidelines. Facility policies/procedures for admission to the secured memory care unit and use of the WanderGuard system was requested. The administrator stated on 8/22/13, at 12:00 p.m. they did not have either of these policies or procedures. The facility initiated an IJ removal plan which included elopement assessments and care plans updated, daily checks of resident bracelet of all residents with WanderGuards, testing the monitor operation of the WanderGuard system (door locations) elevator door and the north door on first floor. The results of these tasks were checked on every shift. The plant Operations Director adjusted the door closer located on the stairwell door to ensure the door properly latched, the facility Vulnerable Adult (VA) Reporting Action Plan protocol was amended to ensure appropriate responses to all elopements, and training of staff on these changes. On 8/23/13, between 8:42 a.m. and 9:05 a.m. 12 staff members of various departments were	F 323		

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F 323	Continued From page 61 interviewed to ensure they had knowledge and had been provided education by the facility regarding elopement training and monitoring of the facility WanderGuard system. Chemicals were found unlocked in the secured memory care unit with wandering residents placing them at risk. During observation of the facility between 12:55 p.m. and 2:00 p.m. on 08/19/13, the first floor secured memory care unit, had a door labeled, "Resident Bathroom." A male resident (unidentified) had previously exited the bathroom independently. The door remained half opened, and contained a sink, toilet and can of Spartan Chemical Airlift, Fresh Scent (aerosol air fresher) in a gray cup holder attached to the wall approximately four feet high which was readily accessible for resident use. During observation of the environmental tour at 9:00 a.m. on 08/23/13, with the facility's director of environmental services (DES) and a maintenance tech (MT), the secured unit first floor "Resident Bathroom" was again half opened. The room contained a can half full of Spartan Chemical Airlift, Fresh Scent (aerosol air fresher) in a gray cup holder attached to the wall, that was approximately four feet from the floor. There were no residents in the area. The DES stated the resident bathroom door does not lock since it is a memory care unit. DES verified the aerosol air fresher on the wall was accessible to residents and stated, "We should probably lock that up." During interview on 8/21/13 at 12:00 p.m., with the DON stated there were seven residents (R83,	F 323		

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F 323	Continued From page 62 R60, R73, R32, R64, R40, and R68) that independently wandered on the secured memory care unit. Review of the Material Safety Data Sheet (MSDS) on the Spartan Chemical Airlift, Lemon, fresh and Smoke and Odor Eliminator, indicated it contained, "aliphatic petroleum distillates, and propane and isobutane." Health Hazard Data section indicated, "May cause eye irritation. Do not get in eyes..." Emergency and First Aid Procedures section indicated, "Eyes: In case of contact, immediately flush eyes with plenty of water for at least 15 minutes; remove contact lenses. If irritation persists; seek medical attentions. Skin: In case of skin contact, immediately flush with water for at least 15 minutes. Ingestion: If swallowed; drink large quantities of water." Review of the incident/accident reports dated March 2013 through August 2013 did not identify an ingestion of chemicals on the secured memory care unit. Although chemicals were unlocked in the secured memory care unit, this placed seven residents at risk, who wandered the area.	F 323	F 353 The facility does have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessment and individual plans of care. Sufficient Nursing staffing has a potential impact to all residents residing in the facility. For all other residents who may be affected by this practice the daily schedules will be reviewed by the Director of Nursing or designee each day before posting to ensure designation of charge nurse, to ensure an RN is on the schedule, and to ensure adequate staffing is present.	
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	F 353	The staffing concerns were addressed with R112, R41, R13, R79, R50, R12, R114, R53, R5 and R2.	

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F 353	Continued From page 63 The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate staffing to ensure residents received required assistance with activities of daily living for 10 of 60 residents (R112, R41, R13, R79, R50, R12, R114, R53, R5 and R2) who resided in the facility with complaints of insufficient staffing. There was 1 of 4 family members (F)-A interviewed that had complaints of call lights were not being answered timely due to lack of staff. Additional there was 1 of 5 staff members that complained there was not sufficient staffing to complete there work timely. Findings include: R112 complained the facility was short staffed and her call light was not answered timely.	F 353	Nursing staffing is calculated based on the acuity of the resident population within the facility. Nursing staffing policies account for the call –ins by adjusting the employee to the weekend they would be off if they call on a Friday, Saturday or Sunday for their shift. The policy and procedure for nursing staffing will be reviewed and revised by the DON on 10/2/13. A review of policies by the Medical Director will be conducted to ensure current standards of practice are in place. Staff members will be trained as it relates to their respective roles and responsibilities regarding the Nursing Department Staffing policy and procedures on 10/2/13. The perception of nursing staffing shortage will be addressed in the licensed staff meeting on 10/2/13. Staffing of current positions and	

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F 353	Continued From page 64 R112 was admitted on 8/13 with diagnosis of right ankle fracture. R112's care plan dated 8/9/13 indicated she was oriented to self, place, time and person. The care plan also indicated she is non-weight bearing on her right leg and needs extensive assistance from staff for transfers. During interview on 8/20/13 at 12:47 p.m., R112 stated she had recently admitted to the facility and when she first arrived at the facility she had her call light on for almost an hour before someone would answer it. R112 further stated she had to wait too long several times to use the bathroom and became incontinent of urine, which was "frustrating" for R112. During observation 8/22/13, R112 call light was turned on at 10:12:00 a.m. at 10:44 a.m., surveyor entered room. R112 stated " I have been waiting along time today for help they really must be backed up today." At 10:45 a.m., staff answered R112's call light and assisted R112. R112's call light was on for 33 minutes before staff had answered her light. Review if R112's call light response time logs from 7/25/13 to 8/22/13, identified R112's call light response time on 16 occasions was between 20 to 95 minutes before was answered. R41 complained the facility was short staffed and his call light was not answered timely. R41 admission minimum data set (MDS) dated 7/03/13 indicated he was cognitively intact and needed extensive assistance with activities of daily living (ADL's).	F 353	hours worked will be adjusted based on the needs of the residents. The facility is routinely advertising open positions via websites and newspapers and held a job fair on 9/18/13. The nursing department ensures that the cares are complete for the shift by signing off on toileting sheets for the units worked and turning them in that the end of the shift. The DON will audit the compliance of the toileting sheet completion on a weekly audits will be completed regarding completion of assignments of care for the group of residents for six months to ensure compliance with results reported to the QA Committee for review and further recommendation Call light times are reviewed by the DON on a monthly basis and reviewed at the facilities quality council on a quarterly basis for trends. The call light times will be further evaluated by the DON and staffing	

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F 353	Continued From page 65 During interview 8/19/13 at 6:11 p.m., R41 stated " I wish they had more staff. I spoke with social services and they claim they go by a formula." R41 further stated several times a week he waits 30 minutes to an hour for help. His longest wait was in the mornings and had told the resident council about his concern. Review if R41's call light response time logs from 7/25/13 to 8/22/13, identified R41's call light response time on 20 occasions was between 20 to 65 minutes long. R13 complained the facility did not have enough staff and has had accidents due to not having enough staff to assist her. R13's quarterly MDS dated 7/31/3 indicated she was cognitively intact and needed extensive assistance with ADL's. R13's most recent care plan dated 7/28/13 indicated she needed assistance with toileting and was continent of bowel. During observation on 8/19/13, at 6:20 p.m. R13 was laying in bed with her call light on yelling for "help." During interview on 8/19/13, at 6:30 p.m., R13 stated she was so frustrated that it takes so long for the staff to answer her call light. She has told the social worker and the director of nursing (DON) her concerns but they tell me they have enough staff. R13 stated having to wait happens on a daily basis. At 6:36 p.m. nursing assistant (NA)-D answered R13's call light and repositioned her in bed.	F 353	coordinator to plan for adjustment of hours where needs are greater for the residents by 10/15/13. The Administrator will monitor the on-going compliance of maintaining appropriate nursing staffing hours. Completion date: October 15, 2013.	

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During interview on 8/22/13, at 10:00 a.m. R13 family (F)-Z stated the facility needs more staff. R13's call light was on for over an hour a few weeks ago and she was incontinent of bowel because she had to wait so long. She complains to the staff all the time that her call light is not answered timely and nothing changes.

R79's family (F)-A had concerns that R79 did not receive a shower in a timely nor was her call light consistently answered timely.

R79 had diagnoses of anxiety and depression. R79's quarterly MDS dated 6/24/13 indicated she was moderately cognitively impaired and needed extensive assistance with ADLs. R79's care plan dated 4/05/13 indicated she needs assistance with bathing.

During interview on 8/22/13, at 11:30 a.m. with F-A stated they are at the facility every day and the facility needs more staff. R79 did not receive a shower at all, at least the first two and half weeks she was there. F-A also stated it took a long time for the staff to respond to her call lights which happens on a daily basis.

Review if R79's call light response times from 3/18/13 to 4/18/13, identified R79's call light was on 65 times for greater than 20 to 65 minutes.

Review of R79's point of care history report 3/18/13 thru 4/18/13 verified she did not receive a bath or shower for the first two and half weeks she was at the facility.

During interview on 8/22/13, at 11:00 a.m., with

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Registered Nurse (RN)-B verified R79 did not receive a bath the first week she was at the facility but thought she had received one during the second week but could not find any documentation to verify that.

A 90 day call light response audit was requested from the DON on 8/22/13 at 1:00 p.m., she stated they were only able to provide 30 days of call light audits of their reports.

R50 complained the facility was short staffed and her call light was not answered in a timely manner.

R50 was admitted on 5/13 with diagnoses that included inability to care for herself at home, incontinence and morbid obesity. The admission MDS dated 5/28/13 indicated R50 had no cognitive impairment and needed extensive assistance with all ADL's except for eating.

During an interview on 8/20/13, at 8:15 a.m., R50 stated there may be enough staffing during the day, but "not at night", "there just is not enough aides for everyone here". R50 stated "the other day nursing assistant [(NA)-E] came to help me transfer to to commode. [NA-E] called on the walkie 10 times" and finally had to put on the call light after he got frustrated. Someone then came in five minutes, "they are not supposed to use the call light to call each other, they use talkies first."

During continuous observation of the call light marquee system outside of the second floor nursing station on 8/22/13 from 9:52 a.m. through 10:35 a.m. R50's pressed her call light on at 9:52 a.m. for assistance. At 10:09 a.m., R50 stated "my light has been on since quarter to nine." At

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F 353	Continued From page 68 10:22 a.m. R50 stated she put her light on to get up for the day and I have had to go to the bathroom too." At 10:35 a.m. R50's call light was shut off when a nursing assistant entered her room, which was a total of 43 minutes before R50's call light was answered. Review of R50's call light response time indicated between 7/25/13 to 8/22/13, the response time on 37 occasions was between 20 and 118 minutes long. R12 complained the facility was short staffed and his call light was not answered in a timely manner. R12 was admitted on 9/12 with diagnoses that included a neurological disease, withe paralysis. The quarterly MDS dated 7/9/13 indicated R12 had no cognitive impairment and was total dependent on staff for ADL's. During an interview on 8/20/13 at 12:36 p.m., R12 stated he "had a problem with not enough staffing at times...there just isn't enough". R12 stated it is worse from 2:30 p.m. - 10 p.m., when staff helps residents to the kitchen for dinner and then they want to go to bed and they are "busier than heck, they could use more help". "I blow into my device but it can take anywhere from 20 minutes to an hour, I am just concerned when it takes too long". Review of R12's call light response time indicated between 7/26/12 and 8/23/13, the response time on 39 occasions was between 20 and 89 minutes.	F 353		

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F 353	Continued From page 69 R114 complained the facility was short staffed and his call light was not answered in a timely manner. R114 was admitted on 8/13 with diagnoses of heart disease and a stroke. The admission MDS dated 8/19/13 indicated R114 had moderate cognitive impairment and required extensive assist with ADL's and was frequently incontinent of urine. During an interview on 8/22/13 at 9:28 a.m., R114 was visibly and verbally upset about long staff waiting times. He stated "today I put on my light on both on the bed and pendant at 8:03 a.m. and at 8:35 a.m. noon came," so I got up and dressed myself and then an aide came in to help with the bed. R114 stated "I am supposed to wait for help, but I needed to go to the bathroom two times so I went by myself" and then to the dining room by myself. I pushed my light a couple of times and no one came. R114 stated "See that red tape on my walker, that means I should wait for help but I would still be waiting if I did that." During continuous observation of the call light marquee system outside of the second floor nursing station on 8/22/13 from 10:13 a.m. through 10:53 a.m.. R114 had turned his call light on at 10:13 a.m. The light remained unanswered until 10:53 a.m., a total of 40 minutes before the call light was responded. During an interview on 8/22/13 at 2:50 p.m., R114 stated "at 10:00 a.m. I was waiting for assistance" and sometimes the pendant goes on because I have this heart pillow and it pushes up against it. "No one came in for that whole time to check".	F 353		

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Review of R114's call light response time indicated between 8/1/13 to 8/22/13, the response time on 20 occasions was between 20 and 89 minutes.

R53 complained the facility was short staffed and his call light was not answered in a timely manner.

R53 had diagnoses including left hemiplegia, personality disorder, chronic pain. The quarterly Minimum Data Set (MDS) dated 8/6/13 indicated the resident had no cognitive impairment and was extensive assist for all activities of daily living (ADL's) except eating.

During interview on 8/20/13 at 9:50 a.m., R53 stated there was not enough staff but thought days was the worst. R53 stated she will go down for a meal and come back to her room and the only way I can get help to go to the bathroom is to sit in my door and wait for someone to go by. R53 further stated "I put on my light but that doesn't help, sometimes 45 minutes to an hour is not unusual"

Review of R53's call light response time indicated between 7/26/13 to 8/23/13, the response time on 110 occasions was between 20 and 191 minutes.

The facility failed to responded promptly to resident council grievances about staffing concerns for 4 of 6 monthly resident council meeting minutes (March 2013, April 2013, July 2013 and August 2013) for 4 of 4 residents (R53, R12, R5, R2) who complained of staffing concerns. Refer to F244 for additional

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F 353	Continued From page 71 information. STAFFING INTERVIEW: During an interview on 8/21/13, at 3:15 p.m. trained medication aide (TMA)-A stated they do not have enough help on the night shift. Often they will have four or five residents up on the memory care unit during the night, someone has to keep an eye on them, do rounds, and answer call lights. "We can not get to call lights very quickly, we just don't have enough time. I have to be rude to the residents and rush them to potty, so I can get onto other residents who need help." During an interview on 8/23/13 at 3:47 p.m., staffing coordinator (SC) stated she uses a formula that was given to her by the facility to determine the staffing hours for direct care staff. SC stated that she has been told by residents that staffing is an issue, but "I have heard that for 20 years". SC further stated that the facility population is more complex and since short term rehab has come on it has been a change..."we have a few residents that demand more time". SC stated we have had a lot of call ins in the past few weeks but we usually fill the shift or I or clinical managers will fill in.	F 353	F 356 The facility does post the required staffing information each day. Posted nursing hours contain the information of: facility name, the current date, the total number of actual hours worked by the following categories of licenses unlicensed nursing staff directly responsible for resident care per shift. Registered nurses, licensed practical nurses, certified nurse aides and resident census. The hours posting was updated on 8/26/13 to include the actual number of each person in each position that comprises the total number of hours worked. The facility will conduct random audits of posted nurse staffing information. Results of the audits will be brought to the Quality Assurance (QA) meeting each month. Education was provided to the staffing coordinator regarding the	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for	F 356		

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

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F 356	Continued From page 72 resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the required information for nursing hours on a daily basis at the beginning of each shift. This had the potential to affect all 60 residents residing in the facility. Findings include: During the initial tour at 12:55 p.m. on 08/19/13, a posting of the nurse staffing data was observed on a bulletin board by the 2nd floor nursing station. Although the name of the facility, date, and census were included in the posting, the total	F 356	posted nurse staffing information requirements on 8/26/13 The DON will monitor for on-going compliance. Completion Date: September 26, 2013.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 356	Continued From page 73 number of licensed and unlicensed staff were not identified for each shift. The staff nurse posting dated 08/19/2013 indicated for the 6:00 a.m.-2:30 p.m. shift- "8 RN [registered nurse], 16 LPN [licensed practical nurse], 8 TMA [trained medication aide] and 56 NA/R [nursing assistance/ registry]. During interview with staffing coordinator (SC) and director of nursing (DON) at 12:35 p.m. on 08/23/13, confirmed they took turns completing the staff nurse posting daily and had been using the same form for a few years. During interview SC verified that, "6:00 a.m.- 2:30 p.m. shift- 8 RN [registered nurse], 16 LPN [licensed practical nurse], 8 TMA [trained medication aide] and 56 NA/R [nursing assistance/ registry]" meant the actual hours worked by those disciplines, not the number of actual staff working. SC stated she was unaware of needing to have the actual number of staff listed next to the actual hours worked for each discipline and shift.	F 356	F 363 The facility does ensure that menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences and are prepared in advance and followed. Dietary aides and cooks involved have been disciplined and re-educated regarding the menu expectations. All residents with altered diets have been identified at risk.	
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the posted menu was followed and available to resident's	F 363	The facility policy and procedure regarding menu standards and the updated prep and daily menus have been re-educated to all culinary staff. Extension/Prep menus for the staff have been updated to include alternatives for those on altered diets. Daily menus for residents have been updated to reflect the	

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F 363	Continued From page 74 who required a modified diet. This practice had the potential to affect 4 of 4 current residents (R47, R116, R15, and R1) who received a pureed diet. Findings include: During dining observation on 8/19/13, at 5:02 p.m. the menu posted in the memory care unit included: chicken salad sandwich, cole slaw, potato chips, and apricots. The alternative menu for residents not wanting the main menu was: pork riblet, mashed potatoes, and gravy. While observing this dining service, it was noted that R47, R15, and R1 were not provided a choice in menu items. Each of these residents was given a plate of pureed/ground pork riblet, mashed potatoes, gravy and peas. When interviewed on 08/19/13, at 5:32 p.m. dietary aide (DA)-A stated the residents who need a pureed diet can only get the riblet, mashed potatoes, gravy and peas as, "you can't puree chicken salad as it has celery in it and it would have strings. You can't puree coleslaw or chips." DA-A also stated there was always an alternate of soup, but residents on pureed diets do not get to have soup either as they never puree the soups. During dining observation on the memory care unit, on 8/20/13, at 8:45 a.m. for the Sunrise Snack, the menu posting indicated: danish, yogurt, cold cereal. R47, R15, and R1 all received oatmeal and beverages, nothing more. Oatmeal was not identified on the menu. The memory care dining was observed again at 11:08 a.m. The Brunch menu posting included: scrambled eggs, toast, Salisbury steak, mashed potato, gravy, and creamed spinach. R47, R15,	F 363	choices for those on a therapeutic diet. Tray cards also indicate the residents' diet order. The Culinary Services Director or designee will complete a weekly menu audit to ensure menu is being followed. Results of the audit will be brought to the QAA meeting each month. The Administrator will monitor for on-going compliance. Completion Date: October 15, 2013.	

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F 363	Continued From page 75 and R1 all received the Salisbury steak, mashed potato, gravy and instead of creamed spinach, they received pureed peas. During dining observation on 8/21/13, at 9:10 a.m. for the Sunrise Snack, the menu posting indicated: Cinnamon toast, yogurt and cold cereal. Again R47, R15, and R1 received only oatmeal, and no other items that were identified on the menu. Oatmeal was not on the menu. During dining observation on 8/23/13, at 9:15 a.m. for the Sunrise Snack, the menu posting indicated: Cinnamon toast and cold cereal. R47, R15, and R1 only received oatmeal. At 10:30 a.m. the posted Brunch menu indicated: french toast, sausage patty, pork chop, mashed potato, gravy, peas, and peaches and cream. R47, R15, and R1 all received the pureed pork chop, mashed potatoes and pureed carrots. They did not receive pureed peas as identified by the menu but received pureed carrots instead. When interviewed on 8/23/13, at 10:08 a.m. R47 stated, "I wish I could get what the others get for food." R47 stated it does bother her that she can't get breakfast items at the brunch time particularly. She has asked in the past, and has been told it doesn't come in puree. Review of R47's quarterly Minimum Data Set (MDS) dated 7/1/12, indicated she was cognitively intact. When interviewed on 8/23/13, at 10:35 a.m. DA-B stated they do not puree soups which are always offered as an alternative, the residents with pureed diets could only have the mashed potato, gravy, and pork chop, they do not get a choice of the sausage or french toast. DA-B stated french toast and sausage can not be pureed. DA-B	F 363		

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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 363	Continued From page 76	F 363		

stated the cook had pureed carrots, because they were left over from a different meal, the pureed diets could not have peas as posted on the menu.

When interviewed on 8/23/13, at 11:30 a.m. the culinary service director (CSD) stated the residents on pureed diets got carrots today instead of peas, because peas are hard to puree. When it was pointed out that residents at the 8/19/13 evening meal, who were on pureed diets received pureed peas, the CSD just shrugged her shoulders. CSD stated the peas for the 8/19/13 evening meal was a substitute for the cole slaw as cole slaw can not be pureed.

During an interview on 8/23/13 at 3:40 p.m., the facility's registered dietician (RD) stated the residents with pureed diets should be receiving the same food as was posted on the menu. The RD was not aware this was not occurring and stated chicken salad, coleslaw, peas, and almost any item, can be pureed. However, the facility quit trying to puree bread products a few years ago because residents did not eat it. The RD also stated that she was not aware residents on pureed diets were only receiving oatmeal for the Sunrise Snack.

When interviewed again on 8/23/13 at 4:15 p.m., the CSD stated staff were utilizing left overs for the pureed diets at times. The Sunrise Snack time, residents can have oatmeal which was always available, or they can have packets of cream of wheat cereal. The CSD agreed these items were not on the posted menu and stated the staff did not puree other breakfast items such as eggs, pancakes, french toast, sausage, bacon, or other bread products. The CSD went on to state that when the main menu includes items

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F 363	Continued From page 77 such as rice, pasta, bread, baked potato, or scalloped potato, the facility serves mashed potatoes only to those who receive a pureed diet. Other potato types are not available for those who require pureed food. The CDS stated pureed bread often ends up in a gummy ball, and the resident's did not like it, so they quit trying to puree bread products a few years ago. CSD stated their food service vendor does offer pureed bread products, but they are expensive, while the facility currently has only four residents on a pureed diet. During review of each resident's diet card with the CSD, identified that R115 received the same menu choices as R1, R47, and R15. During interview on 8/23/13, at 4:30 p.m. Cook-C stated she had pureed the left over carrots for the brunch meal as they were left overs and needed to be used. A review of the menu used in the kitchen was provided for the week of 8/19/13 through 8/25/13, it identified each item that could or could not be provided for those residents who required a pureed diet. The menu did indicate the chicken salad sandwich served on 8/19/13 was available for puree, as was the cole slaw. Mashed potatoes were available to those on a pureed diet. For the Sunrise Snack meal on 8/20/13, the menu indicated the danish could be served as a "slurry." There was no indication that toast, cold cereal, scrambled eggs, could be pureed. The facility provided a National Dysphagia [difficulty swallowing] Diet; Pureed guidelines undated. The guidelines included a recommendations for mashed potatoes or sauce, pureed potatoes with gravy, butter, margarine, or sour cream. Well-cooked pasta, noodles, bread	F 363		

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F 363	Continued From page 78 dressing, or rice that have been pureed in a blender to smooth, homogenous consistency. Soups that have pureed in a blender or strained, and pureed vegetables without chunks, lumps, pulp, or seeds. A facility policy entitled Menu Standards, dated 2012, included under number eight, "Menus for modified and therapeutic diets are patterned after the regular diet menus as closely as possible." Number 11, "Menus for all regular and therapeutic diets, including pureed and mechanical soft diets, are planned in advance, doted, and followed as written, per state and federal regulations." Number 13, "When changes or substitutions in the menus are necessary, the substitutions must provide equal nutritive value. Substitutions are made in writing on the menus in Culinary Services for regular and therapeutic diets before the meal is served..." Number 15, "...Daily menu extensions of regular and modified diets are posted or available during meal service where they can be clearly read by staff assembling the meals and trays."	F 363	F 371 The facility does- (1) Procure food from sources approved or consider satisfactory , by Federal, State, or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. Culinary staff involved in the dining observations has been counseled regarding failure to complete temperatures as required. All residents have been identified at risk.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Facility has created a policy and procedure regarding food temperatures to ensure all hot and cold foods are checked in accordance with regulations and are within the proper temperatures before serving to prevent potential food borne illness. All culinary staff will be educated to this policy/procedure by 10/15/13.	

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F 371	Continued From page 79 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe food temperatures were attained, as well as proper equipment sanitation procedures were followed. These practices had the potential to affect 58 of 58 residents who were served food out of the kitchen. Findings include: Food temperatures were not checked for cold food items at the point of service. In addition, re-heated foods were not checked to ensure they had been heated to the proper temperature before serving to prevent potential food borne illness. During dining observation on 8/19/13, at 5:13 p.m. dietary aide (DA)-A checked the temperature of the hot foods but did not check the temperature of the cold foods, which included chicken salad and beverages. DA-A stated these items were not checked because they came from the refrigerator and were placed on ice. During dining observation on 8/23/13, at 10:30 a.m. DA-B checked the temperatures of the hot foods. DA-B did not check the temperatures of the cold foods, which included canned peaches with half and half cream. The bowls of peaches and cream were sitting in individual bowls on a tray next to the steam table. The bowls felt room temperature to touch. DA-B was directed to check the temperature of the peaches and cream by the surveyor, and received a temperature reading of 59 degrees Fahrenheit (F). DA-B was unsure of what the temperature of the cold items	F 371	All culinary staff will be retrained with a return demonstration to proper food temperature techniques by 10/15/13. Exposed wood surrounding the cooler doors has been repaired to ensure a cleanable service. Monthly cleaning schedules have been updated to include the cleaning of the walk-in cooler doors. The facility cleaning procedures policy has been updated to outline the cleaning of the cooler doors. Daily cleaning lists for culinary staff have been updated to reflect cleaning the cooler doors. All culinary staff has been re-trained to the facility policies and procedures regarding Dishwashing procedures and Dishwashing Temperature Monitoring Logs Policy. The Culinary Services Director will complete weekly sanitation audits which will include the	

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F 371	Continued From page 80 should be, because they do not check the temperature of these items. DA-B stated she had never been trained to check the temperature of cold items, even though she had been working at the facility for two years. In addition, DA-B stated left over carrots were pureed for those residents receiving pureed diet. DA-B was directed to check the temperature of the pureed carrots, and placed a thermometer into the steamer pan touching the bottom of the pan, and was directed to ensure the tip was actually in the food and not the pan temperature. The temperature of the carrots were 159 degrees F. DA-B dropped the entire thermometer into the pureed carrots while checking the temperature, when completed, she only disinfected the tip of the thermometer. DA-B did not know what temperature the pureed left over carrots had been heated to, prior to placing them on the steam table. DA-B did not know what temperature re-heated items were required to be heated to, to prevent the risk of food born illness. During interview on 8/23/13, at 11:30 a.m.,. the culinary services director (CSD) stated the peaches and cream should have been placed on ice and she was not aware they had not been. Canned peaches, at room temperature, had been placed in individual bowls and half and half poured on them around 8:30 a.m. they were then placed in the cooler until removed for service about 10:30 a.m. CSD stated they do not check the temperature of cold items, either in the kitchen prior to service or at point of service. CSD stated the peaches and cream should have been the temperature of the cooler prior to being removed, but had no way of determining if they ever reached the point of service temperature of 41 degrees F. CSD did not know if the carrots	F 371	dishwasher temp logs and food temperatures. Audit results will be brought to the QAA meeting each month. The Administrator will monitor for on-going compliance. Completion Date: October 15, 2013.	

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had been checked to ensure they reached 165 degrees F for 15 seconds or not. They had not checked them to ensure proper re-heating temperature was obtained before service. The CSD stated the facility checks temperatures of only hot food, once on the steam cart, brought to the unit and just prior to serving. The temperatures are checked again when meal service was over. The CSD stated she does not train the staff on how to check temperatures of food, this would be done by another dietary aide as new staff start. CSD does not do any audits to determine if staff are checking the temperature of foods correctly, or consistently.

When interviewed on 8/23/13, at 3:40 p.m. the registered dietician (RD) stated the point of service temperature of cold foods should be 41 degrees or less. The facility should at least check the temperature prior to the food leaving the kitchen. The peaches and cream should not have been served at 59 degrees. She was not responsible for audits of the dietary staff, temperature logs, or training, this was the CSD's responsibility.

A review of first and second floor Food Temperature Record for August 18-24 was reviewed and contained only two cold food temperature entries for this time period.

A facility policy was requested, but not provided by the facility.

Equipment and food preparation areas were not maintained in a clean and sanitary condition.

During tour on 8/22/13 at 10:57 a.m., the following sanitation problems were observed on

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

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tour with the CSD:

The outside molding/edging of the wooden door of the walk in vegetable cooler had chipped and worn off white paint. The wood was exposed and this created a non-cleanable surface. This measured approximately 8" (inches) long and 1" wide located below the handle on the door. To the left of this exposed wood approximately 2" of the molding had a buildup of substance. The right lower corner of the wooden door frame was chipped off and wood was exposed and coated with visible brown substance.

- Two reach in cooler doors approximately 2.5 feet by 2.5 feet had a buildup of debris and substance above each handle.

- The outside molding/edging of the wooden door of the meat cooler had white paint chipped off exposing rough wood which was gouged. This measured approximately 8" long and 1" wide located below the handle on the door. To the right of this exposed wood approximately 1.5 " of the molding had a buildup of grime and dirt. There was various dried food splatter on the lower half of the door.

When interviewed on 8/23/13, at 8:47 a.m. the CSD stated, "Yes, that is dirt on the doors and it should have been cleaned." She verified cleaning the outside of the walk in cooler doors was not on any cleaning assignment, nor in any policy or procedure. Deep cleaning was probably done "about six months ago". She further stated that the exposed wood was not a cleanable surface and a requested for repair should have been written in the maintenance repair book, but this was not done.

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Review of the undated, Daily, Weekly and Monthly Cleaning Schedules for staff and cooks revealed cleaning of the the walk in cooler doors were not on the schedules.

Review of the undated, Benedictine Health Systems Cleaning Procedures policy revealed cleaning the walk in coolers but cleaning of the doors were were not outlined in the policy.

Dishwasher temperatures were not consistently monitored to ensure proper temperatures were conducted.

During the kitchen tour on 8/22/13, at 10:57 a.m. with the CSD, the dishwasher temperature was recorded after each meal. Review of the dishwasher temperature logs for April, May, June, July and August, 2013 indicated the following:

August 2013: all temperatures were recorded, there were 2 final rinse temperatures below 180 degrees F.
July 2013: 13 of 93 dishwasher temperatures had not been recorded, 3 final rinse temperatures were below 180 degrees F.
June 2013: 13 of 90 dishwasher temperatures had not been recorded.
May 2013: 18 of 93 dishwasher temperatures had not been recorder, 1 wash temperature was below 150 degrees F and 1 final rinse temperatures was below 180 degrees F.
April 2013: 30 of 90 dishwasher temperatures had not been recorder, 2 final rinse temperatures were below 180 degrees F.

There were a total of final eight rinse temperatures below 180 degrees Fahrenheit (F),

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F 371	Continued From page 84 and there were 74 opportunities in the past five month which temperatures were not recorded at all. When interviewed on 8/23/13, at 8:47 a.m. the CSD verified the lack of temperature documentation and stated she would expect staff to consistently document on the temperature log. The CSD stated staff are instructed to record the dish machine temperatures "after a couple of loads so that the dishwasher can get up to temperature. They must have recorded them before that, it is just something that we know to do," The CSD further stated staff are instructed to call her immediately if the dish machine temperatures are below required level. Review of the facility Dishwashing Temperature Monitoring Logs policy, dated 2000, included, "a log must be completed by those who are directly involved in the dishwashing process. Entries must be made daily...Temperature and /or PPM [parts per million] that are below required levels are reported to the Dietary Director immediately for correction of problem before continuing procedure. It is the responsibility of the Dietary Director to monitor daily completion of the dishwashing temperature logs." Review of the Dishwashing Procedures policy dated 2000 included, "temperature of the water shall be maintained at 140-160 degrees F for the washing cycle and at 180 degrees F for the rinsing and sanitizing cycle".	F 371	F 441 The facility does maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease an infection. All laundry aides involved in the observations were counseled and re-educated regarding the policy and procedure for linen handling. All residents were identified at risk. The facility has updated the laundry handling policy and procedure. All laundry and housekeeping staff will be educated to this policy/procedure by 10/1/13. Impervious gowns were purchased and all staff was educated regarding the location and expectations surrounding the equipment use.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 85 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 441	The Environmental Services Director will complete monthly audits to ensure staff is following procedures. Results of these audits will be brought to the QAA meeting. The facility has created an employee illness tracking policy and procedure. All managers will be in-serviced to this policy and procedure by October 1, 2013. DON will audit tracking each week and bring the results of the audits to the Quality Assurance (QA) meeting each month. The Administrator will monitor for on-going compliance. Correction Date: October 1, 2013	

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F 441	Continued From page 86 review, the facility failed to ensure potentially contaminated laundry was handled in a manner to prevent cross contamination. In addition, the facility did not track or trend employee infections, and compare these to resident infections to determine any potential cross contamination. These issues had the potential to affect all 60 of 60 residents currently residing in the facility. Findings include: Potentially contaminated laundry was sorted without adequate clothing protection. Laundry assistant (LA)-A was observed sorting soiled laundry on 8/21/13, at 7:05 a.m. LA-A wore a long sleeve, cloth gown and gloves as protection for sorting soiled laundry. LA-A stated the gown was not impervious to fluids and does occasionally get wet. After sorting dirty laundry, LA-A placed the sorted dirty items into the washing machine, and then removed her gloves and gown, washed her hands, and then brought in a clean wire basket for the clean laundry. LA-A stated the clean laundry gets brought into a different room where there are dryers and a folding table. LA-A stated there was a plastic apron available for use when sorting dirty items, but we only uses it for "bloody items." During interview on 8/23/13, at 10:00 a.m. housekeeper (HSK)-B demonstrated how laundry was sorted. HSK-B wore a long sleeved cloth hospital gown. HSK-B stated she does not wear the, impervious to fluids gown or plastic apron unless items come in that are marked from an infection control room, or items contain with blood, or when filling washing chemicals.	F 441		

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F 441	Continued From page 87 During interview with the director of environmental services (DES) on 8/23/13, at 2:30 p.m. she stated, "We don't use the plastic apron for anything, because we are a nursing home, we don't experience isolation laundry very often." DES was unaware of the potential for contaminating clean laundry with clothing that could potentially have become contaminated through the cloth gown the attendants were using to sort the soiled clothing. An undated Procedure for Sorting Soiled Linens included the need to put on gloves and gown for sorting soiled laundry, but failed to include the need to wear something impervious to fluids. The facility did not have any system in place to track and trend employee infections. Review of the infection control logs from January through July 2013, identified specific resident names, admission dates, room unit, type of infection, body site, date of onset, organism, antibiotic and if they were community acquired or not. There was no indication that any employee's infections were tracked as part of the facility infection control logs. During interview and review of the facilities infection control program with the director of nursing (DON) on 8/23/13, at 9:20 a.m. she stated they do not have a tracking system for employee infections. Generally employees do not state the reason for their illness. Therefore, there was no way to determine if any resident infections were related to employee illnesses. They continued to state they did some tracking during influenza season last year in which two	F 441		

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employees had influenza but they typically do not track employee illnesses.

A facility policy dated 6/2001, entitled Infection Control included under Standard 2, number 4, "Staff with communicable diseases are prohibited form direct resident/tenant care." Number 5. "Staff members handle, store, process, and transport linens to prevent the spread of infection." The policy failed to include how employee infections would be tracked, trended, or compared to resident infections.

F 465 SS=E

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 and interview, the facility failed to develop and conduct a system to ensure a functional, clean environment related to lack of maintenance, repair and upkeep of multiple resident room floor surfaces, a baseboard heater vent and a bathroom room door within the facility that affected 2 of 2 units, 8 out of 11 resident rooms on the memory care unit, and 1 out of 19 rooms on the 2nd floor unit which affected 10 residents in these rooms.

Findings include:

During the environmental tour on 8/23/13, at 9:00 a.m. with the facility's director of environmental

F 441

F 465

F 465

The facility does provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

Flooring in the identified rooms of 100, 104, 112, 118, 126, and 132 will be replaced with new flooring. Project will be complete by October 6, 2013.

Baseboard in the identified rooms of 100, 126, and 132 has been repaired. Baseboard in the enclosed nurses' station baseboard was repaired.

Toilets identified in 100, 104, 118, 122, 126, and 132 have all been re-calked around the base of the toilet.

Leaking toilets in 112 and 124 have been repaired.

The baseboard heater identified in room 238 has been repaired.

The bathroom door in 132 has been repaired.

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
	245459	A. BUILDING ______ B. WING ______	C 08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 465	Continued From page 89 services (DES) and a maintenance tech (MT)-A, the following was noted and verified: Resident rooms 100, 104, 112, 118, 126 and 132 resident floors in rooms and bathrooms had black "tile glue" around floor tiles in which dirt was stuck to it. DES stated, "It is glue from under the tile coming up." DES also verified on tour, "The floors are from the original building construction dated back to 1960..., the floors need to be replaced, administration knows this." Resident rooms 100, 126 and 132 in the bedrooms and bathrooms, the baseboard was pulling away from the wall. It was also observed by the 2nd enclosed nurse's station, the corner of the wall the floor base board was pulled away from wall and sticking outward with the potential for any resident or person to get hooked on. Resident rooms 100, 104, 118, 122, 126 and 132 in the bathrooms had cracked and missing caulking around the toilet alone the floor, which also had black dirt stuck in it, all the way around the base of the toilets. Resident bathrooms 112 and 124 had brown stained flooring around the toilet and it was observed both toilets were leaking water. MT stated, "I didn't get a work slip, but it appears the whole toilet needs to be replaced." Resident room 238, behind resident's bed, had a baseboard heater vent that was pulled away from the wall and had several dents located on the top. MT stated, "It looks like the electric bed had been lowered down on it, I was not aware of this, it will need to be fixed."	F 465	All residents have been identified at risk. Facility has updated the floor care policy and procedure to ensure floor care is maintained and flooring needing repair or replacement is identified in a systematic way. Staff involved in floor care were re-educated to the new policy by 10/1/13. All resident rooms and bathrooms have been audited and repairs made as found/needed. All main/common areas in the facility have been audited and repairs have been made as found/needed. The facilities deep cleaning policy and procedure and deep cleaning check off sheet has been updated to ensure proper reporting of items needing repair. All environmental and maintenance staff were re-educated regarding the updated policy/procedure, and check off sheet by 10/1/13.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING ____ B. WING ____	C 08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 465	Continued From page 90 In addition, resident bathroom door in room 132, was observed to be have a large chip, approximately 5 inches by 5 inches, located in the inner part of door near door frame. During the environmental tour on 8/23/13, at 9:00 a.m. the DES and MT-A stated resident rooms and common areas are cleaned daily. Each month a deep cleaning is done. All staff are trained to complete an entry in the maintenance book with any equipment or environmental concerns; which is located at both of the nurse's stations on 2nd floor and 1st floor. If the concern is emergent, MT-A has a cell phone that is answered all of the time. DES stated, "We have safety rounds that are completed monthly by all staff disciplines... staff rotate and walk the rooms and grounds to observe any potential concerns. Review of the facility's policy, Deep Cleaning Procedure Check Off Sheet, undated, included, "To ensure the cleanliness of the resident room and equipment (wheelchairs, walkers, etc.), each room is scheduled once per month and has a deep cleaning done... Please note any concerns for safety and enter in the maintenance requisition book. Other sanitation concerns should be noted and brought to your supervisor."	F 465	Environmental Services Director will monitor the deep cleaning through audits each week. The results of the audits will be brought to the QAA meeting. The Administrator will monitor the on-going compliance. Completion date: October 7, 2013.	
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently	F 496		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING ______ B. WING ______	C 08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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F 496 Continued From page 91

successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to verify 1 of 51 nursing assistants employed at the facility were on the state nursing assistant registry. This had the potential to affect all 60 of 60 residents currently residing in the facility.

Findings include:

Review of nursing assistant (NA)-K employment file, did not identify if he was on the state's nursing assistant registry.

F 496

F 496

The facility does verify that the nursing assistant is on the MN nursing assistant registry and in good standing prior to employment. When the nursing assistant is not yet registered, the facility ensures that the background check is reviewed for ability to care for vulnerable adults.

The employee identified was verified as required. A background check was complete as the employee was not on the registry at time of hire but had completed the nursing assistant course.

Staffing coordinator and HR were re-educated to the facility policy and procedure on 9/20/13. Audits of new nursing assistant files will occur each month. Results of the audits will be brought to QAA.

The DON will monitor for on-going compliance.

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
	245459	A. BUILDING ______ B. WING ______	C 08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

(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 496	Continued From page 92 During an interview on 8/23/13, at 4:41 p.m. human resource staff (HR)-L stated that NA-K started his employment at the facility on 7/3/13. The first day of his employment, NA-K reported to her that he was not on the nursing registry as he had just passed the nursing assistant test. She indicated she asked him to provide documentation of this, which he did not provide. HR-L acknowledged she had not contacted the nursing registry at any point during his employment to determine his status on the registry roster and should have done so when he started his employment, and was still employed by the facility. Verification of the nursing assistants on the registry roster revealed NA-K had not been placed on the registry until 8/6/13, 33 days after he was employed by the facility.	F 496	Completion Date: September 20, 2013.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/30/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH** **WINSTED, MN 55395**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 30, 2013. At the time of this survey, Building 01 of Benedictine Living Community Winsted, d.b.a., St. Mary's Care Center, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us	K 000	RECEIVED SEP 23 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok [initials] 9-24-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/CEO — (X6) DATE: 9-20-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/30/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH** **WINSTED, MN 55395**

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Benedictine Living Community Winsted, d.b.a., St. Mary's Care Center was constructed as follows: Building 01 consists of the original 1960 building. It is 2-stories in height, has no basement, is fully sprinklered and was determined to be of Type I(332) construction; Building 02 consists of the 2011 building addition. It is 1-story in height, has no basement, is fully sprinklered and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**08/30/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH** **WINSTED, MN 55395**

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K 050 — Continued From page 2

varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on review of reports and records, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 60 residents, visitors and staff.

Findings include:

On facility tour between 9:00 AM and 12:00 PM on 8/30/2013, a review of the available fire drill reports revealed that the facility's Day-shift fire drills in 2012 and 2013 were conducted between the hours of 1:00 PM, 9:40 AM, 1:00 PM, 10:30 AM, and the Night-shift fire drills between 3:30 AM, 1:00 AM, 5:00 AM, 3:00 AM not at varied times as required by Section 19.7.1.2.

This deficient practice was confirmed by the facility 's Asst. Maintenance Manager.

K 050

K 050

Plant Operations Manager and Environmental Services Director will complete fire drills in accordance with NFPA 101 LSC. The facility has updated the fire drill policy and procedure and fire drill schedule. The Plant Operations Manager and Environmental Services Manager will be trained to the updated policy and procedure and schedule by September 18, 2013. The Plant Operations Manager and Environmental Services Director will complete a facility fire drill September 19, 2013. Plant Operations Manager or Environmental Services Director will complete monthly drills thereafter. Plant Operations Manager will be responsible for the on-going compliance.

Corrected Date: September 19, 2013

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

F 5459022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING 02 - NEW MAIN ENTRANCE B. WING	08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 30, 2013. At the time of this survey, Building 02 of Benedictine Living Community Winsted, d.b.a., St. Mary's Care Center, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.

Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to:
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar St., Suite 145
St Paul, MN 55101-5145, or
By email to:
Barbara.Lundberg@state.mn.us and,

DC: 10.02.2013

Exit: 08.23.2013

RECEIVED
SEP 23 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
PS 9-24-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/CEO — (X6) DATE: 9·20·13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245459	A. BUILDING 02 - NEW MAIN ENTRANCE B. WING	08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	551 FOURTH STREET NORTH WINSTED, MN 55395

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Benedictine Living Community Winsted, d.b.a., St. Mary's Care Center was constructed as follows: Building 01 consists of the original 1960 building. It is 2-stories in height, has no basement, is fully sprinklered and was determined to be of Type I(332) construction; Building 02 consists of the 2011 building addition. It is 1-story in height, has no basement, is fully sprinklered and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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
	245459	A. BUILDING **02 - NEW MAIN ENTRANCE** B. WING	**08/30/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY WINSTED	**551 FOURTH STREET NORTH** **WINSTED, MN 55395**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 60 residents, visitors and staff. Findings include: On facility tour between 9:00 AM and 12:00 PM on 8/30/2013, a review of the available fire drill reports revealed that the facility's Day-shift fire drills in 2012 and 2013 were conducted between the hours of 1:00 PM, 9:40 AM, 1:00 PM, 10:30 AM, and the Night-shift fire drills between 3:30 AM, 1:00 AM, 5:00 AM, 3:00 AM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility 's Asst. Maintenance Manager.	K 050	K 050 Plant Operations Manager and Environmental Services Director will complete fire drills in accordance with NFPA 101 LSC. The facility has updated the fire drill policy and procedure and fire drill schedule. The Plant Operations Manager and Environmental Services Manager will be trained to the updated policy and procedure and schedule by September 18, 2013. The Plant Operations Manager and Environmental Services Director will complete a facility fire drill September 19, 2013. Plant Operations Manager or Environmental Services Director will complete monthly drills thereafter. Plant Operations Manager will be responsible for the on-going compliance. Corrected Date: September 19, 2013	