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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6XPG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00110

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245510**
2.STATE VENDOR OR MEDICAID NO.
(L2) **414490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVANSVILLE CARE CENTER**
(L4) **649 STATE STREET NORTHWEST**
(L5) **EVANSVILLE, MN** (L6) **56326**

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) **09/23/2009**

6. DATE OF SURVEY **01/31/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Tammy Williams, HFE NEII **02/01/2017** (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist **04/14/2017** (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/19/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5510

On January 31, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 4, 2017, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of January 10, 2017. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, as of January 10, 2017.

As a result of the revisit findings, the Department discontinued the Category 1 remedy of State monitoring, effective January 10, 2017.

In addition, the Department recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of December 16, 2016:

- Civil money penalty for the deficiency cited at F314, remain in effect (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 1, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify the facility of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights. Refer to the CMS 2567b forms for both health and life safety code.

Effective January 10, 2017, the facility is certified for 40 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245510

April 14, 2017

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, Minnesota 56326

Dear Mr. Borgstrom:

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 January 10, 2017 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 1, 2017

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, Minnesota 56326

RE: Project Number S5510027

Dear Mr. Borgstrom:

On December 16, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 21, 2016. (42 CFR 488.422)

In addition, on December 16, 2016, 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 F314. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 1, 2017. (42 CFR 488.417 (b))

Futhermore, as we notified you in our letter of December 16, 2016, 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 March 1, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on December 1, 2016. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On January 31, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 4, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 1, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 10, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 1, 2016, as of January 10, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring, effective January 10, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies recommended in our letter of December 16, 2016:

- Civil money penalty for the deficiency cited at F314, remain in effect (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 1, 2017, be rescinded. (42 CFR 488.417 (b))

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245510 Y1	A. Building B. Wing Y2	1/31/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0314	Correction	ID Prefix F0325	Correction
Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.25(b)(1)	Completed	Reg. # 483.25(g)(1)(3)	Completed
LSC	01/10/2017	LSC	01/03/2017	LSC	01/10/2017
ID Prefix F0333	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(f)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/10/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	02/01/2017	32603	01/31/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/1/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245510	A. Building 01 - MAIN BUILDING 01 B. Wing	1/4/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 01/01/2017	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 01/01/2017	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 (INITIALS) TL/mm	DATE 02/01/2017	SIGNATURE OF SURVEYOR 36536	DATE 01/04/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/30/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6XPG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00110

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245510**
2.STATE VENDOR OR MEDICAID NO.
(L2) **414490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVANSVILLE CARE CENTER**
(L4) **649 STATE STREET NORTHWEST**
(L5) **EVANSVILLE, MN** (L6) **56326**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **09/23/2009**

6. DATE OF SURVEY **12/01/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Tammy Williams, HFE NEII 01/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5510

On December 1, 2016, a standard survey was completed at ther facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in ther facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), The facility will not be given an opportunity to correct as a result of the survey findings and the following remedy will be imposed:

• State Monitoring effective December 21, 2016. (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 for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

• Mandatory Denial of payment for new Medicare and Medicaid admissions, effective March 1, 2017. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Evansville Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation
Programs for two years effective March 1, 2017.

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 16, 2016

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, Minnesota 56326

RE: Project Number S5510027

Dear Mr. Borgstrom:

On December 1, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

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

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

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.

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:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited. A level G deficiency (isolated deficiencies that constituted actual harm that was not immediate jeopardy) was cited on the current survey. Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 21, 2016. (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 for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions, effective March 1, 2017. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Evansville Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 1, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 March 1, 2017 (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 June 1, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	12/01/2016

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EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services as directed by the care plan for repositioning for 1 of 3 residents (R32) who was reviewed for pressure ulcers, and failed to implement care plan interventions for nutrition for 1 of 3 residents (R15) reviewed for significant weight loss. Findings include:	F 282	An assessment was immediately conducted following the survey on 12/07/2016 for resident R15. It was determined that all of the previous interventions that were in place were appropriate and resident will continue to receive this plan: Offer high calorie foods, such as: 1/2 and 1/2 daily with cereal, Extra butter on pancakes, waffles, French toast, and toast. Extra gravy or butter on potatoes. Magic cup, qd. this will aide in	1/10/17

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

Electronically Signed | 12/27/2016

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F 282	Continued From page 1 R15's Care Plan dated 10/11/16, identified R15 's care plan goals were to maintain goal weight of 119# within 5% through 12/29/16. The care plan identified R15 required supervision with eating related to confusion. The care plan directed staff to monitor R15's food intake and offer her substitutes if she wasn't eating, and supervise and cue R15 as needed. The care further identified staff were to refer R15 to occupational therapy (OT) and the registered dietitian (RD) for evaluation and recommendations as needed, and weigh R15 weekly. On 11/30/16, from 12:15 p.m. to 12:55 p.m. R15 was observed seated in her wheelchair at the dining room table in the back of the dining room against the window. R15 was quiet and continually looked down towards her lap, and appeared very thin. R15 took only bites of her meal (carrot coins, Salisbury steak, mashed potatoes and gravy, pickle, and grapes). R15 struggled to eat and put an empty fork up to her mouth, and was unable to get food to stay on her fork. Nursing assistant (NA-E) was seated at R15's table assisting R39 and R4. NA-E asked R15, "Are you going to eat some more of your meat.?" R15 replied, "I'm not hungry." NA-E' walkie-talkie sounded, and she discussed the new admissions across the dining room with NA-F and NA-G, and assisted R39 and R4 with their meal. Towards the end of the meal NA-E pushed R15's grapes across the table to R15 and asked, "Do you like your grapes?." R15 replied, "I'm full." NA-E nodded her head up and down at R15 and repeated back to her, "Your full." R15 had her whole meal in front of her and fiddled with her white paper napkin. NA-E removed her plate and R15 wheeled herself out of the dining room. R15 was not adequately supervised and	F 282	adequate nutrition for resident. The nursing staff is made known of the care plan interventions by utilization of the kardex on the POC and the meal name tag. This will allow the staff to be better informed of resident□s meal time interventions. The dietary staff is made know of the interventions by the meal name tag and the dietary communication board/book. Nursing staff will record the percentage of all additional supplements consumed, including the magic cup or other additional supplements. This will be recorded separately from the meal time food consumption in the MAR. All residents have the same equal potential to be affected by this specific deficient practice. Education will be provided to all staff on engaging residents in appropriate meal conversations and how to approach a resident who is having difficulty focusing at meal time. This will be covered in a mandatory in-service by the Director of Nursing. Education will be provided on use of the Kardex for CP interventions on the POC and meal name tag. Education will be provided on how to identify when someone is requiring help to eat, when to promote independence and interventions per care plan to implement when they are not eating. Supervision, cuing and how to provide physical aid will be addressed. This will be covered in a mandatory in-service by occupational therapy and the	

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F 282	Continued From page 2 cued during the meal, and no menu substitutions were offered during this time period. On 11/30/16, from 5:48 p.m. to 6:42 p.m. R15 was observed seated in her wheelchair at the dining room table in the back of the dining room against the window. R15 appeared restless and confused. R15 ate only bites of her meal (ground beef, rice and pepper casserole, mixed vegetables, mandarin oranges and ice cream-like nutritional supplement in a covered, styrofoam container(Magic Cup). R15 picked up her silver teaspoon, examined it and put it back on the table. R15 picked up the magic cup and poked the bottom of the cup with her spoon. R15 tried to tear open the cup, and then picked up her fork and stabbed the container. R15 became frustrated and pushed the magic cup away from her. R15's casserole had large parsley sprigs on top that R15 picked up and put in her mouth. R15 immediately started spitting and took out of her mouth fingers and put on plate. NA-C took the top off the magic cup when she delivered R15's meal and walked away. R15 continued to struggle and try to open the magic cup even after NA-E took the lid off. NA-C was seated at R15's table assisting R4 and R13. R15 struggled to eat her meal with a fork and food fell off the fork onto the table and her lap. R15 stated, "This fork is so dumb you can't work with it." NA-C and R15 laughed. NA-C asked R15, "Is it good.?" R15 replied "I'll manage." R15 continued to struggle with the magic cup packaging. R15 reached across the table and spilled her bowl of mandarin oranges and R15 and NA-C laughed. Res used a spoon and took a bite of her magic cup and stated out loud, "That's good ice cream." NA-C repeated to R15, "That's good ice cream." R15	F 282	consulting dietitian. Policy will be implemented of general dietary guidelines in assisting residents with meal time. Staff will be made aware of this policy during mandatory in servicing. This policy will be posted in the sunrise dining room for future references. In addition to the shift to shift verbal report between the nursing assistants, a reposition flow sheet will be initiated to ensure a better continuity of care. The repositioning sheet will include time last repositioned, if resident is in the facility and if they were toileted. This sheet is started at 0600 and is utilized for 24 hours. These sheets are to be destroyed upon completion of the noc shift at 0559 after a verbal report is given. An audit of random CNAs on all shifts will be conducted to monitor the use of the kardex and CP interventions weekly x 4 weeks then monthly. An audit will be conducted on personnel assisting with feeding a resident as well weekly X4 weeks then monthly. The audit will include knowledge of the kardex and CP interventions, basic dietary etiquette and adequate assist for residents who are requiring assistance with eating. The repositioning sheets will be monitored daily X1 month. Weekly X3 month and monthly X 8 months. This will be completed by January 10th 2016.	

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F 282	Continued From page 3	F 282		

took several bites of her magic cup and then filled the styrofoam cup with her casserole. R15 was not adequately supervised and cued during the meal, and no menu substitutions were offered during this time period.

On 11/30/16, at 6:06 p.m. NA-C stated she felt R15 usually ate really good on the evening shift, and stated she didn't know how R15 ate at other meals. She stated she was not aware that R15 had lost any weight. She stated every once in awhile R15 needed encouragement to get started but that was about it. She stated interventions included warming R15's food up if it got cold and a magic cup every night at supper. She stated R15 didn't always eat her magic cup, and stated she felt R15 would benefit from adaptive silverware for eating because her depth perception was not good. She stated R15's favorite foods included ice cream, sweets, potato cheddar soup, and R15 would eat anything if she could put her own salt on at the table.

On 11/30/16, at 6:09 p.m. NA-B stated R15 didn't always take her magic cup, and stated R15 refused it every other night, or every 2 nights. She stated R15 didn't like cold food. She stated she felt R15 usually ate less than 50% of her meals, and really liked ice cream and sweets. She stated she felt R15 had lost about 20#, but stated she wasn't sure. She stated the magic cup and a glass of beer were R15's nutrition interventions. She stated she felt R15 may benefit from adaptive silverware (colored) and stated she felt R15's depth perception was bad.

On 11/30/16, at 6:46 p.m. NA-A stated R15 ate an average of about 50% of her meals and her

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F 282	Continued From page 4	F 282		

intake varied. He stated he felt R15 had not lost weight. He stated R15 received a magic cup, and stated he wasn't sure how often R15 received it. He stated she liked the magic cup, and ice cream. He stated he felt if someone sat next to R15 it would help R15 eat better. He stated he thought the only nutrition intervention for R15 was the magic cup.

On 11/30/16, at 6:56 p.m. director of nurses (DON) confirmed nutrition interventions from 10/4/16 nutrition assessment and stated they included magic cup, adding butter to meals or other high calorie foods. DON confirmed R15's current care plan which included supervision and cueing R15 to eat, and offer R15 meal substitutions if she didn't eat well. She stated she expected the care plan to be comprehensive, and followed.

On 12/1/16, at 1:50 p.m. FSD confirmed R15 had last been assessed 10/4/16 by the RD. She stated she was unaware of R15's significant weight loss, or that R15 had any eating problems. She stated a comprehensive nutritional assessment was only done on admission. She stated R15's weight loss should have been identified right away and they should have intervened immediately. She confirmed R15's last nutritional assessment was completed 10/4/16 and interventions included magic cup, beverage or food of choice, may add 2 butters to each meal or other high calorie, high protein foods. She stated she wasn't sure if the interventions were being done, but stated she had told staff a while ago. She stated there is always room for error, and it was hard to remember everything sometimes. She stated either the dietary associate (DA) or the NA added the high

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F 282	Continued From page 5 calorie, high protein foods for R15. She stated staff were supposed to offer R15 beverages and food substitutions if she wasn't eating well. She stated after the RD assessed R15, she was responsible for implementing recommended interventions, and updating the care plans with nursing. FSD stated R15's food intake was 50-75%, with a few meal intakes of 25% meals, and intake of R15's magic cup was not recorded. She stated if R15 had problems eating, or was eating poorly, staff were to offer her substitutes, encourage and cue her, and monitor her weight weekly, and report changes to the nurse. She stated R15 could have been referred to the RD and OT, and staff should have reported resident ' s nutrition problems before now. She confirmed R15's care plan should have been followed, and it wasn't. She confirmed R15 had not been offered substitutes, and was not cued to stay on task at meals. She confirmed R15's care plan failed to identify all of the RD's recommendations and interventions. Review of the facility policy, Dietary/Nutrition Care Plan dated 11/92, identified the facility was to monitor and document progress in achieving goals with approaches as identified in the comprehensive care plan.	F 282		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 314		1/3/17

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F 314	Continued From page 6 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive reassessment was completed, and failed to implement interventions, to prevent the worsening of reoccurring pressure ulcers for 1 of 1 resident (R32) reviewed with current stage 3 and stage 4 pressure ulcers. This deficient practice resulted in actual harm for R32 whose stage 3 and stage 4 pressure ulcers deteriorated. Findings include: R32's significant change Minimum Data Set (MDS) dated 2/9/16, identified R32 had independent daily decision making skills, and had diagnoses which included coronary artery disease, pressure ulcer to left hip and right buttocks, and anxiety. The MDS identified R32 required extensive assist of two staff for bed mobility, transfers and toilet use. The MDS identified R32 had one stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough; may also present as an intact or open/ruptured blister); and one stage 3 pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle is not	F 314	Resident R32 has had a significant noted decline both physically and cognitively within the month of November. Discussed this with the family via the phone. This was also discussed with resident's provider on 11/25/2016. Resident admitted to Douglas County Hospice on Friday December 2nd at 2:00pm. The goal was aimed to ensure residents maximum comfort. Resident passed away on December 14th 2016. The comprehensive assessment process for tissue integrity was reviewed. A revised policy was developed and will be implemented. A systematic approach, specifically aimed at pressure ulcer follow-up was implemented. Pressure ulcers will now be submitted through the risk management tab and all weekly documentation will be centralized to allow for better continuity. A wound monitoring template has been developed for both daily wound monitoring and weekly wound monitoring. The facility will continue to utilize the weekly wound	

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F 314	Continued From page 7 exposed, slough may be present but does to obscure the depth of tissue loss and may include undermining and tunneling) which were present upon admission/entry or reentry. R32's MDS further listed pressure ulcer interventions including a pressure relieving device for the chair, turning/repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer care for R32. R32's Care Area Assessment (CAA) dated 2/9/16, indicated R32 was alert and orientated, refused the use of an alternating pressure pad and repositioning, and had been educated on the importance of repositioning. The CAA identified R32 had one stage 2 pressure ulcer and one stage 3 pressure ulcer to left hip and right buttock. The CAA further identified R32 was at risk for development of further pressure ulcers, required staff assistance with bed mobility, and was frequently incontinent of urine. The CAA further indicated R32 required a special mattress or seat cushion and a regular schedule of turning every hour. R32's quarterly MDS dated 5/9/16, identified R32 had moderate impaired cognition and had no behaviors or rejection of cares. The MDS identified R32 was at risk for pressure ulcers, had two stage 2 pressure ulcers, two stage 3 pressure ulcers and no stage 4 pressure ulcer (Full thickness tissue loss with bone exposed, tendon, muscle, slough or eschar tissue may be present on some parts of the wound bed, often including undermining and tunneling). R32's quarterly MDS dated 8/8/16, indicated R32 had moderately impaired decision making skills, and had no behaviors or rejection of care. The	F 314	monitoring sheets as well. The facility will be utilizing the services of a wound consultant who will be at the facility bi-weekly. This will allow for greater communication. The nursing staff at the facility will round with the wound consultant and a discussion will be held with each round including wound care, resident compliance, any education and expectations of wound healing. The progress notes that are accumulated from the wound consultant and the weekly wound note will be printed for the primary MD to review with routine rounds. The nursing staff will be made aware of any changes to wound care by utilizing the dashboard and the MAR/TAR. Wounds will be discussed with family upon observation of the wound, quarterly and if a significant change were to occur. With these conversations wound care, resident compliance, any education and expectations of wound healing will be discussed. The format for the care conference note was changed to better reflect what is discussed during the meeting. The care conference review will be sent via mail to the family if they are not able to attend. In addition to the shift to shift verbal report between the nursing assistants, a reposition flow sheet will be initiated to ensure a better continuity of care. The repositioning sheet will include time last repositioned, if resident is in the facility and if they were toileted. This sheet is started at 0600 and is utilized for 24 hours. These sheets are to be destroyed upon completion of the noc shift at 0559	

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F 314	Continued From page 8 MDS indicated R32 required extensive assistance of two staff for bed mobility, transfers and toilet use, and indicated R32 had one stage 2 and one stage 3 pressure ulcer which were present upon admission/entry or reentry. The MDS also indicated R32 had one stage 4 pressure ulcer which had not been present upon admission/entry or reentry. The MDS listed pressure ulcer interventions including use of a pressure relieving device for the chair, turning/repositioning program, nutrition or hydration intervention to manage skin problems, pressure ulcer care and applications of ointments/medications for R32. R32's quarterly MDS dated 11/7/16, identified R32 had moderate impaired daily decision making skills, both short term and long term memory problems and rejection of cares less than daily, behaviors not directed at others less than daily. The MDS indicated R32 required extensive assist of two staff for bed mobility, transfers and toilet use, and identified R32 as having one stage 1 pressure ulcer (intact skin with non-blanchable redness of localized area usually over bony prominence), one stage 3 pressure ulcer, and one stage 4 pressure ulcer, which were present upon admission/entry or reentry. R32's current care plan revised on 11/30/16, identified R32 had dementia, hallucinations and pressure ulcers to right buttocks, right ischial tuberosity, left iliac crest and left hip. R32's care plan also indicated R32 required assist of 2 staff and a full mechanical lift for transfers. Interventions included: extra protein in diet (resident has been resistive to other supplements), seen by wound specialist (treatment as ordered, notify the wound specialist	F 314	after a verbal report is given. Education will be completed by the Director of Nursing in regards to how and when to approach a resident after a care is refused and the clinical documentation on refusal of care. Daily monitoring of the risk management tablet will be completed by the Registered Nurse of any new pressure areas or areas of unexplained injury. This will ensure that a 24 hour follow-up and assessment will be completed upon observation of a pressure ulcer. Pressure areas will be monitored daily by the AM shift nurse and a full weekly assessment will be conducted by the Registered Nurse. Bi-weekly review by the wound consultant will be completed in the facility with all wounds. The findings that are collected bi-weekly will be discussed in our quarterly quality meetings. The repositioning sheets will be monitored daily X1 month. Weekly X3 month and monthly X 8 months. This will be completed by January 3rd 2017.	

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if area worsens or does not improve), prefers to sit up in wheelchair the majority of the day or side of bed (encourage repositioning), pressure relieving cushion provided for the wheelchair, reposition every hour is offered (resident will many times refuse), and rest back in recliner or in bed for 1 hour in AM (morning) and 1 hour mid afternoon with heels floated as ordered.

R32's current Resident Care Sheet dated 11/29/16, identified R32 had pressure sores, required assist of one staff for bed mobility, for repositioning every hour, did not ambulate and required assist of two staff for transfers using full mechanical lift.

On 11/30/16, at 3:05 p.m. R32 was observed lying on her left side, covered with blankets, resting quietly. A standard wheelchair with a black foam cushion was observed in R32's room near her bed. At that time, nursing assistants (NA)-B and NA-C entered R32's room to provide personal cares. NA-B and NA-C removed R32's covers and the pillow from behind the right side of her back, R32 was observed to be lying on a regular mattress. R32 had an indwelling catheter in place and had been incontinent of a medium soft dark black bowel movement, which was noted to extend from the bottom of her left iliac crest dressing, all the way down to the top of her right lower buttocks dressing. At 3:10 p.m. NA-B was observed to clean R32's buttocks with wipes, then removed the soiled 3 inch (in) x 3 in dressing from R32's left iliac crest, which had a moderate amount of yellow drainage noted on the foam dressing, NA-B discarded the soiled dressing into the soiled brief then proceeded to remove a soiled 4 in x 4 in dressing from R32's right lower buttocks which had a moderate amount of yellow

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drainage noted on it. R32 was observed to have a pink 4 x 4 in intact foam dressing on her left hip and another noted on her left lower buttocks.

At 3:12 p.m. licensed practical nurse (LPN)-B entered the room, while NA-B and NA-C were caring for R32. LPN-B had them reposition R32 to her right side so she could dress her ulcers. During the wound care, R32's right lower buttocks was observed to have an open wound which measured approximately 3 cm (centimeters) x 4.5 cm x 2 cm deep, with tunneling at approximately 4 o'clock and 9 o'clock, the wound bed was noted to be very dull pink/gray color with slough (dead tissue that may have a yellow or white appearance) noted throughout. The outer skin around R32's ulcer was dark purple/red in color with scar tissue present, which extended out approximately 2 inches around the entire opening of the the ulcer, and faded to a red/pink color further out from the opening of the ulcer. R32's skin around the ulcer was not blanchable. R32's left iliac crest had an open wound which measured approximately 2 cm x 2 cm x 1 cm deep, with an excoriated area that extended out from the right surface of the wound at about 5 o'clock measuring approximately 1 cm x 0.5 cm. The wound bed was noted to be a very dull pink/gray color with slough noted throughout the wound bed. The outer skin around the ulcer was dark purple/red in color with scar tissue present, which extended out approximately 1 inch around the entire opening of the the ulcer and faded to a red/pink color further out from the opening of the ulcer, the skin around the ulcer was not blanchable, there were multiple light tan scabs noted from the bottom of R32's left iliac crest opening to the top of her anus area, which was also noted to be bright red in color. The skin

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where the two pink intact foam dressings were located, on the left hip and left lower buttocks, was observed to be red around the outer edges of the dressings.

At 3:18 p.m. NA-B indicated she did not know the last time R32 had been repositioned on the day shift because the day staff had not reported to her the last time R32 had been repositioned. NA-B stated R32 was sleeping when she got to work and had not been repositioned at 2:15 p.m. when she had arrived at work.

At 3:24 p.m. LPN-B indicated R32 had pressure ulcers for years and indicated the ulcers get better, then come back. LPN-B also confirmed R32 had a current stage 4 ulcer on her right lower buttocks with tunneling present on both sides of the ulcer, a stage 3 ulcer on her left iliac crest, and LPN-B indicated she had not seen R32's other breakdown areas on her left hip and left lower buttocks. At 3:35 p.m. LPN-B and NA-B transferred R32 via mechanical lift from her bed to her wheelchair and placed a blanket on her lap and shoulders. A seat cushion was in the wheelchair. At 3:44 p.m. LPN-B and NA-B placed a tray with a cup of coffee and bar, and exited the room.

During continuous observations on 11/30/16, at 4:25 p.m. R32 was seated in a standard wheel chair in her room, with a walker/tray in front of her, door partially closed, with blankets on her shoulders and lap.
At 4:34 p.m. R32 remained seated in her wheelchair in her room, and yelled "help, help, help."
At 4:40 p.m. NA-B entered R32's room and offered to reposition R32. R32 stated, "No." NA-B

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exited the room.
At 5:00 p.m. R32 remained seated in the regular wheel chair and yelled "help, help, help." NA-B briefly entered R32's and exited the room. R32 remained in the position in her wheelchair. NA-B was not observed to offer R32 repositioning.
At 5:15 p.m. NA-A entered R32's room briefly and informed R32 it was almost supper time. After NA-A exited the room, R32 remained in her room, seated in her wheelchair, in the same position. NA-A had not offered or assisted R32 to reposition.
At 5:25 p.m. NA-A again entered R32's room and assisted R32 to propel her wheelchair into the dining room. NA-A did not offer or assist R32 to reposition.
At 5:39 p.m. R32 was observed to be calmly seated at a table and visiting with table mates.
At 6:00 p.m. R32 remained seated in the wheelchair and staff delivered her supper meal, she immediately started eating the meal independently.
At 6:17 p.m. R32 remained seated in the wheelchair until NA-D assisted her out of the dining room and into the living room area.
At 6:31 p.m. R32 was observed propelling herself down the hallway of the facility. NA-A approached R32 and assisted R32 back to her room. NA-A exited the room at 6:33 p.m. and did not offer to reposition or assist her to reposition.
At 6:48 p.m. NA -B and NA-C entered to assist R32 for evening cares. R32 remained seated in her wheelchair in the same position.
At 6:54 p.m. NA-B and NA-C transferred R32 via mechanical lift from her wheelchair to the edge of her bed. R32 went directly from the wheelchair to the bed without being provided pressure relief/offloading. NA-B and NA-C adjusted the pillow around R32 and lifted the head of bed for

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her comfort.
At 6:59 p.m. NA-B and NA-C exited the room.

R32 had not been repositioned or offered assistance to reposition from 4:40 p.m. to 6:54 p.m. (total of 2 hours and 14 minutes).
On 11/30/16, at 7:01 p.m. NA-B stated the last time she had attempted to reposition R32 was before her supper break. She stated R32 required every hour repositioning and needed assistance from staff with all of her ADLs. NA-B indicated R32 was confused, the confusion had worsened, and would refuse cares and repositioning at times.
On 11/30/16, at 7:20 p.m. NA-A stated R32 required assistance with all of her ADLs and was confused. He stated he had not offered R32 repositioning as he did not normally work down this hallway, and felt it was the responsibility of the person working that hallway to reposition R32.

R32's Braden Scale (a tool used to identify risk for skin breakdown/pressure ulcers) assessment tool dated 11/7/16, identified R32 was chairfast, had very limited mobility, had current pressure ulcers to the right buttocks, right ischial tuberosity, left hip, and iliac crest and was at risk for development of pressure ulcers. The form listed R32 refused repositioning at times and refused alternating pressure pad, had pressure relieving cushion in chair, had been educated and physician aware.
Review of R32's Tissue Tolerance Tool form (TTT-tool used to determine skins ability to with stand pressure and determine appropriate turning and repositioning schedules) from 1/29/16, to 8/9/16, revealed the following:
-1/29/16, to be repositioned every hour for sitting and lying. Check for redness, resident has stage

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2, pressure ulcer on right hip, must be repositioned every hour, pressure reduction device to chair, float heels pillow or boots, high protein supplement-ensure.
-2/10/16, to be repositioned every hour for sitting and lying, pressure ulcer on right buttocks, pressure reduction device to chair.
-5/9/16, to be repositioned every hour for sitting, pressure reduction device to chair-ROHO cushion, has air cushion in w/c, resident has pressure ulcers to right buttocks, coccyx and left hip. No tissue tolerance for lying documented.
-8/8/16, to be repositioned every hour for sitting, pressure reduction device to chair-ROHO cushion, resident has pressure ulcers to right buttocks, coccyx and left hip.
-8/9/16, to be repositioned every hour for lying and offer hourly. R32 was not able to reposition self, no pressure reduction device, she is to be repositioned hourly due to pressure ulcers, often noncompliant. TTT shows resident can tolerate up to 1 ½ hours but is repositioned hourly as she allows.

Review of R32's weekly Pressure Skin Condition Reports/Skin Wound Note/Progress Notes from 3/1/16, to 12/2/16, revealed a lack of documentation that a comprehensive skin assessment had been done when R32 developed the ulcers. The notes also revealed the following related to R32's wounds:
- 3/1/16, pressure ulcer to left hip was unchanged from last week, stage 2, measuring 0.5 centimeters (cm) x 0.7 cm, wound bed 100% slough, dressing applied, right buttocks, stage 3 no wound bed visualized, no measurements, treatment applied right buttocks stage 2 right below stage 3 ulcer, 100% granulation tissue, no measurements, treatment applied, left heel has

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F 314	Continued From page 15 resolved, left ischial tuberosity- reddened area noted after bath, no open area. - 3/8/16, right buttocks stage 3 unchanged, no measurements, right buttocks stage 2 right below stage 3 resolved, Desitin applied, left hip stage 2 measures .0.5 cm x 1.0 cm, wound bed 100% slough, new dressing applied. - 3/11/16, new ulcer to left iliac crest, stage 2, measuring 3.5 cm x 1.2 cm, red bloody, no slough. Documentation listed no current interventions. - 3/15/16, right buttocks stage 3 no measurements, no documentation, left hip stage 2 measures 0.3 cm x 0.5 cm, wound bed 100% granulation, left iliac crest, stage 2, measuring 1.7 cm x 1.2 cm, 50% black and 50% granulation tissue. Documentation listed no current interventions. - 3/23/16, right buttocks stage 3, small open area measures 0.3 cm x 0.2 cm, left hip stage 2, no change, measures .0.3 cm x 0.5 cm, wound bed 100% granulation, new Allevyn dressing applied, left iliac crest, stage 3, measuring 2.4 cm x 1.5 cm, 75% granulation tissue and 25% slough, dressing applied. - 3/29/16, right buttocks stage 3, no wound bed to measure, area indented but appears to be how it has healed, dressing applied, left hip stage 2, no change, measures 0.3 cm x 0.5 cm, wound bed 100% granulation, dressing applied, left iliac crest, stage 3, measuring 2.4 cm x 1.4 cm, 100% granulation tissue, on antibiotic due to wound infection, dressing applied, followed by wound specialist. - 4/5/16, right buttocks stage 3, no wound bed visible, dressing applied left hip stage 2, no change, measures 0.5 cm x 0.7 cm, wound bed 100% slough, dressing applied, left iliac crest, stage 3, measuring 2.1 cm x 1.4 cm, 100%	F 314		

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F 314	Continued From page 16 slough, dressing applied, seen by wound specialist on 4/4/16, no changes were made to orders. -On 4/19/16, right buttocks stage 3 has reopened measuring 2.8 cm x 1.5 cm, 100% granulation tissue, cleansed with Chlora-prep, dressing applied per order, left hip stage 2, deteriorating, measures 2.0 cm x 1.0 cm, wound bed 100% granulation, cleansed with Chlora-prep, dressing applied per order, left iliac crest, stage 3, measuring 2.0 cm x 1.5 cm, 95% black eschar, 5% slough, Chlora-prep, dressing applied, New ulcer stage 2 right buttocks 0.5 cm x 0.7 cm, 100% granulation tissue. Wound specialist updated via fax on 4/18/16, regarding new ulcer. -On 4/26/16, measurements from wound specialist: right buttocks stage 3 has measuring 0.5 cm x 3.5 cm, site previously closed ulcer, left hip stage 2, deteriorating, measures 1.7 cm x 0.5 cm, left iliac crest, stage 3, measuring 2.0 cm x 1.5 cm, right buttocks stage 2 measures 0.3 cm x 0.2 cm. Wound specialist ordered continue to cleanse sites, use Allevyn dressing on all sites except right buttock apply skin barrier Cavilon twice a day, keep free of stool, follow up in one month or sooner if need arises, continue to reposition every 2 hours. -On 5/3/16, right buttocks stage 3 measuring 2.5 cm x 1.7 cm, 100% granulation tissue, surrounding tissue deteriorating, left hip stage 2, measuring 2.0 cm x 1.5 cm, wound bed 100% slough, cleansed, dressing applied per order, left iliac crest, stage 3, measuring 2.0 cm x 1.6 cm, granulation and slough with possible amount of necrotic tissue , surrounding tissue deteriorating, right buttocks stage 2 100% granulation tissue, surrounding tissue red/purple but does blanch. Dressing changes completed as ordered. -On 5/31/16, right buttocks stage 3 measuring 1.8	F 314		

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F 314	Continued From page 17 cm x 3.0 cm, deteriorating, macerated with slough, possible depth hard to visualize, area cleansed, left hip stage 2, measuring 1.8 cm x 1.0 cm, wound bed 50% slough, 50 % scabbed, cleansed, dressing applied per order, left iliac crest, stage 3, measuring 2.6 cm x 2.0 cm, 100% stringy slough with possible amount of necrotic tissue, surrounding tissue deteriorating, right buttocks stage 2 area closed last week, measuring 0.7 cm x 0.6 cm, wound bed pink, excoriation distal to this opening, cleansed, dressing applied. Note area of concern to on left ischial tuberosity, areas appear fragile and high risk for breakdown, skin prep applied. -On 6/7/16, right ischial tuberosity stage 3, measuring 2.1 cm x 2.8 cm, deteriorating with slough and eschar present, dressing applied, left hip stage 2, measuring 2.0 cm x 1.0 cm, wound bed 50% slough, 50 % scabbed, cleansed, dressing applied per order, left iliac crest, stage 3, measuring 2.8 cm x 2.1 cm, 95% slough, 5% eschar at bottom of wound, dressing applied, right buttocks stage 2 no wound bed observed to area, tissue discolored red/purple in color, left ischial tuberosity, opened up to stage 2, measuring 2.3 cm x 1.2 cm, wound bed shallow, with one spot of slough, applied dressing. Continues to be followed by wound specialist. -On 6/21/16, right ischial tuberosity stage 3, measuring 3.0 cm x 2.0 cm x 0.4 cm, wound bed beefy with macerated edges, cleansed, dressing applied, left hip stage 2, measuring 1.5 cm x 1.5 cm, wound bed 25% slough, 75 % scabbed, cleansed, dressing applied per order, left iliac crest, has progressed to a stage 4, measuring 2.3 cm x 2.4 cm x .04 cm, wound bed visible dark gray, cleansed, dressing applied, left ischial tuberosity, no wound bed visible, healed. -On 7/5/16, right ischial tuberosity stage 3,	F 314		

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F 314	Continued From page 18 measuring 3.2 cm x 2.4 cm x 1.8 cm, wound bed beefy, cleansed, dressing applied, left hip stage 2, measuring 1.0 cm x 1.0 cm, wound bed slough, cleansed, dressing applied per order, left iliac crest, stage 4, measuring 1.9 cm x 2.0 cm x 1.5 cm, with tunneling at 12 o'clock, wound bed beefy, cleansed, dressing applied, -On 8/2/16, right ischial tuberosity stage 3, measuring 3.0 cm x 1.8 cm x 1.7 cm, cleansed, packing, dressing applied, left hip stage 2, measuring 0.5 cm x 0.7 cm, wound bed scabbed unable to assess, cleansed, dressing applied per order, left iliac crest, stage 4, measuring 2.0 cm x 1.5 cm x 1.5 cm, wound bed 80% slough, 20% pink tissue, cleansed, packing, dressing applied. -On 8/30/16, right ischial tuberosity stage 3, measuring 3.0 cm x 2.0 cm x 2.0 cm surrounding tissue presenting maceration, excoriation and denudement, flushed with normal saline, cleansed, dressing applied, left hip stage 2, is healed, skin light pink where open area was, left iliac crest, stage 4, measuring 3.0 cm x 2.2 cm x 1.2 cm, wound bed deteriorated, area flushed with normal saline, cleansed, skin prep applied, dressing applied. Resident followed by wound specialist. -On 9/21/16, right ischial tuberosity stage 3, measuring 1.5 cm x 2.5 cm x 1.8 cm slight deeper but narrower than last week, dressing saturated with tan colored drainage, left iliac crest, stage 4, measuring 1.7 cm x 3.0 cm x 1.1 cm, depth decreased, width increased with inner edge of wound continuing to breakdown, dressing saturated with tan colored drainage, areas cleansed with normal saline and Chlorhexidine swabs, apply skin prep around wound, dressing applied. -On 10/25/16, right ischial tuberosity stage 3, measuring 2.4 cm x 2.9 cm x 2.4 cm, areas of	F 314		

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F 314	Continued From page 19 discoloration surrounding wound measuring 2.5 cm x 5.0 cm, wound bed more healthy but continues to deteriorate, small amount of drainage, area cleansed and dressed, with no pain, left iliac crest, stage 4, measuring 2.5 cm x 3.2 cm x 1.5 cm, wound larger than last week, edema, redness noted, small amount of drainage, area cleansed and dressed, left hip measured area 1.2 cm x 1.5 cm beginning to look like it breaking down again, covered with non-adherent pad per order. -On 11/1/16, right ischial tuberosity stage 3, measuring 3.2 cm x 4.0 cm x 2.6 cm, area has deteriorated since last week, scant amount of drainage, wound bed light pink/almost gray, area cleansed and dressed, with no pain, left iliac crest, stage 4, measuring 2.5 cm x 3.4 cm x 1.0 cm, wound continues to fill, but breaking down closer to residents midline, wound bed mixture of granulation tissue and slough, small amount of drainage, area cleansed and dressed, left hip measured area 0.3 cm x 0.4 cm beginning to look like it breaking down again, no wound bed, covered with non-adherent pad per order. -On 11/8/16, right ischial tuberosity stage 3, measuring 3.5 cm x 3.5 cm x 3.0 cm, with tunneling at 11 o'clock measuring 4.5 cm, scant amount of drainage, wound bed light pink/gray, area cleansed and dressed, left iliac crest, stage 4, measuring 2.0 cm x 3.0 cm x 1.3 cm, wound bed mixture of granulation tissue and slough, scant amount of drainage, area cleansed and dressed, left hip, no stage, measured 1.4 cm x 1.2 cm no wound bed, area continues to be scabbed, beginning to look like it breaking down again, covered per order. -On 11/15/16, right ischial tuberosity stage 3, measuring 3.2 cm x 4.2 cm x 3.6 cm, with tunneling at 11 o'clock measuring 4.0 cm, wound	F 314		

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F 314	Continued From page 20 continues to deteriorate, wound bed light pink/gray, continue treatment. left iliac crest, stage 4, no measurements, left hip, no stage, measured - no measurements. -On 11/22/16, right ischial tuberosity stage 3, measuring 3.5 cm x 4.6 cm x 2.5 cm, with tunneling at 10 o'clock measuring 4.0 cm, scant amount of drainage, wound bed 25 % sough, remainder gray, area cleansed and dressed per order, left iliac crest, stage 4, measuring 1.9 cm x 3.0 cm x 1.5 cm, wound measures larger, continues to have deeper portion and newer, rolled edges, wound bed 50% slough, 50% pink granulation tissue, small amount of serosanguinous drainage, area cleansed and dressed, left hip, no stage, no change, measured 1.4 cm x 1.2 cm, area continues to be scabbed, covered per order, left ischial, no stage, observed at wound care appointment on 11/21/16, measured 1.6 cm x 1.0 cm, no wound bed, area covered with padded dressing in hopes of preventing further breakdown. -On 11/28/16, right ischial tuberosity stage 3, measuring 3.5 cm x 5.0 cm x 2.3 cm, with tunneling at 10 o'clock measuring 3.5 cm and at 5 o'clock measuring 3.2 cm, this is a deterioration from last week with addition of another area of tunneling and increased width, scant amount of serous drainage, wound bed grayish color, area cleansed and dressed applied, left iliac crest, stage 4, measuring 1.5 cm x 2.5 cm x 0.9 cm, improvement from last week, wound bed 50% slough, 50% granulation tissue, small amount of serosanguinous drainage, area cleansed and dressed, left hip, no stage, no change, measured 0.4 cm x 0.6 cm, slightly smaller than last week, area remains scabbed, covered per order, left ischial tuberosity, measuring, 2.0 cm x 1.5 cm, which is larger, than last week, hard to define	F 314		

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F 314	Continued From page 21 edges of open area, areas cleansed, dressing applied. Review of R 32's wound specialist correspondence from 3/1/16, to 12/1/16, revealed the following: -3/3/16, resolving stage 3 pressure ulcer on left trochanter measuring 0.5 cm x 0.5 cm x 0.1 cm, with stage 1 P/U extending surrounding tissue 2 cm area, nursing home (NH) continue to reposition every 2 hours , apply padding to wheel chair to prevent further breakdown. Buttocks and per-region improved and almost resolved, NH continue Cavilon spray and Calmoseptine daily, with repositioning every 2 hours. Stage 3 P/U to right gluteal fold remains closed. -3/21/16, 3 open areas Left iliac crest, stage 3, 2.0 cm x 1.7 cm x 0.1 cm with 0.6 cm peri meter redden blanchable skin intact, 100% yellow slough, left greater trochanter, stage 3, 0.3 cm x 0.2 cm x 0.1 cm wound culture done, 100% sough, right ischial tuberosity, stage 4, previously resolved, 2.5 cm x 2.0 cm x 0.1 cm, 100% pink epithelial tissue. NH continue to toilet as need, reposition every 2 hours, instruct patient importance of treatments, Foley catheter in place, follow up in 10 days, Levaquin started x 7 days. - 4/4/16, stage 3 to left buttocks , area nearly healed , has now reopened as direct result of shearing from worn out wheelchair padding. Measures 0.3 cm x 0.7 cm x 4 millimeters (mm), left trochanter stage 2, 0.8 cm x 0.3 cm x 2 mm, left ischial tuberosity, stage 2, 1.7 cm x 1.3 cm x 2 mm. Staff to order new, wider chair and pad for the pt as this direct cause of further breakdown and erosion, resident family understands and agrees. -4/11/16, stage 3 to left buttocks , area nearly	F 314		

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F 314	Continued From page 22 healed , has now reopened as direct result of shearing from worn out wheelchair padding. Measures 2 cm x 3 cm x 4 mm, left trochanter stage 2, 1.5 cm x 0.5 cm x 1 mm, left ischial tuberosity, stage 2, 1.7 cm x 1.4 cm x 1 mm, sacrum has now developed stage 1, measures 1 cm x 3.5 cm. Staff to order new wider chair and pad for the pt as this direct cause of further breakdown and erosion, resident family understands and agrees. 4/18/16, wound specialist notified via facsimile of new stage 2 on coccyx area measuring 0.5 cm x 0.7 cm, covered with foam dressing, doctor noted continue to pad areas and monitor, issues will not resolve until patient has appropriate new wheelchair and pad. -4/25/16, 4 open areas- left iliac crest, stage 3, measuring 2.0 cm x 1.5 cm x 0.1 cm, 40% yellow slough, 60% gray slough, right iliac crest, stage 3,measuring 0.3 cm x 0.2 cm 0.1 cm, 100% slough, left greater trochanter stage 3, measuring 1.7 cm x 0.5 cm less than 0.1 cm , 100% slough, previously resolved stage 4 to right ischial tuberosity, measures 0.5 cm x 3.5 cm x 0.1 cm , 100 % pink epithelial tissue. Provider had written order for new wheel chair evaluation and cushion at previous wound care visit, patient received new ROHO cushion on 4/22/16, no documentation of new wheelchair provided. Improvement to peri regions, less pain and eating better, NH staff continue toileting and reposition every 2 hours, Foley catheter in place. -5/19/16, chronic right buttocks stage 2 ulcer, left greater trochanter stage 3 ulcer, left ischial tuberosity stage 3 ulcer, ulcers cleaned and treated, continue same treatments. Continue use of new pad and chair. - 6/20/16, chronic right ischium stage 4 ulcer, right side of tail bone stage 3, left greater	F 314		

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trochanter stage 3 ulcer, ulcers cleaned and treated, treatments Xeroform, skin prep, Allevyn dressing.
- 8/1/16, chronic stage 4 ulcer to right ischium, stage 3 ulcer to sacrum, stage 2 ulcer left greater trochanter, ulcers cleaned and treated, continue same treatment.
- 9/15/16, has stage 4 ulcer to right ischial tuberosity that was previously healed, stage 3 ulcer to sacrum, stage 2 ulcer to right heel, left greater trochanter fully closed. Noticed cushion in wheel chair several pockets are with out air, no longer providing her cushion and off loading that is required, new cushion has been requested by N/H.
- 9/28/16, has stage 4 ulcer to right ischial tuberosity that was previously healed, stage 3 ulcer to sacrum. Patient and family concerned the pad on the wheelchair deflates and is not being checked daily which creates pressure on the right ischium and right sacrum. Orders for nursing staff to inspect her seat pad daily and reinflate daily.
-10/6/16, has stage 4 ulcer to right ischial tuberosity that was previously healed, stage 3 ulcer to sacrum, ulcers cleaned and treated and instruction for wheel chair needs to be replaced , no exceptions!!
10/18/16, wound specialist notified via facsimile R32's pressure ulcers getting worse with odor, more drainage.
-10/20/16, has stage 4 ulcer to right ischial tuberosity that was previously healed, stage 4 ulcer to sacrum, started an antibiotic for wound infections.
- 11/10/16, has stage 4 ulcer to right ischial tuberosity that was previously healed, stage 4 ulcer to sacrum.
Review of R32's progress notes from 3/1/16 to 12/1/16 revealed the following:

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F 314	Continued From page 24 -3/10/16, cooperative with repositioning -3/18/16, has not been compliant with repositioning. -3/31/16, confused and hallucinating, has been compliant with repositioning. -4/4/16, seen by wound specialist, no changes in wound care orders, did comment that resident needs a new wider wheelchair and cushion. -4/6/16, cooperative with repositioning and is laying in bed off of pressure sores resting at this time. -4/14/16, refusing to be repositioned as scheduled." -4/21/16, continue to pad areas and monitor, issues will not resolve until the patient has appropriate wheelchair pad. -4/23/16, has been cooperative with repositioning, asked to be repositioned from the wheel chair to the bed. R32 has been requesting repositioning frequently through out the shift. -5/4/16,will be discharged from occupational therapy on 5/10/16 due to no further changes to wheelchair cushion as is not eligible by the insurance. The goal is for the resident to continue with optimal pressure relief with every hour repositioning. -5/10/16, was compliant with position changes tonight. -5/12/16, has refused reposition several times. " -6/2/16, seen by wound specialist, facility had communicated wounds were looking worse from last appointment and requested R32's plan of care and goals for wound healing be discussed. The wound specialist had replied wounds stable and improving, goal of wound care to prevent infection and keep from deteriorating or new	F 314		

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pressure ulcers developing. Healing may occur in long range but unable to relieve source of wounds which is pressure.

-6/9/16, compliant with repositioning.

-6/10/16, refuses to reposition every hour, repositioned 3 times though out shift. "

-6/30/16, wound specialist had called faciilty after recent visit to notify them R32's tailbone had broken down, necrotic tissue debrided. He also indicated he was aware resident is difficult but needs to air out areas as much as possible and too much chair time will only continue to worsen area.

-7/5/16, compliant with repositioning with night.

-7/17/16, resident was compliant with all repositioning.

-8/2/16, semi complaint with repositioning tonight, did refuse times three this night

-8/4/16, cooperative with standing to repo

-8/27/16, refused to reposition from sitting in her wheel chair, she would only stand for a few seconds on legs

-8/30/16, compliant with repositioning this night

-9/9/16, non-compliant with repositioning or elevating legs

-9/15/16, compliant with repositioning

-10/4/16, compliant with repositioning

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F 314	Continued From page 26 -10/7/16, refused to reposition from wheel chair to recliner or to bed before supper. " -10/21/16, staff encouraged R32 in repositioning and she was compliant -11/7/16, compliant with repositioning -11/11/16, has been repositioned either every hour or two hours form siting at the edge of her bed or lying in bed -11/16/16, compliant with repositioning after supper -11/29/16, has been quite cooperative with repo. She did request repositioning several times in one hour this afternoon -11/30/16, has been complaint with repositioning On 12/1/16, at 7:43 a.m. LPN-C indicated she understood R32 required repositioning every two hours or more and indicated she was not aware of the assistance she needed with ADLs. LPN-C indicated R32's cognition fluctuated at times, and had memory problems. LPN-D indicated R32 was non-compliant with her ADL s at times, sometimes she does really well and other times your not getting anywhere with her. LPN-C indicated the facility had tried to educate family on her repositioning needs and had tried different things to get her to sit on the edge of the bed by giving her treats or pudding to reposition. LPN-C did not offer any other interventions or devices that had been attempted to assist R32 with positioning in a chair or bed.	F 314		

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F 314	Continued From page 27 On 12/1/16, at 8:14 a.m. LPN-D stated R32 needed assistance with all of her ADLs and thought she required repositioning every hour. LPN-D indicated R32 was very confused at times and had increased behaviors of hollering out. LPN-D indicated R32 had current pressure ulcers, and indicated R32 could be non-compliant with repositioning and staff educate her on why she needs to be off her sores. She stated, "It doesn't work, she doesn't care." On 12/1/16, at 12:55 p.m. NA-E confirmed R32 needed staff assistance with all ADLs and required repositioning by staff every hour. NA-E indicated R32 was confused at times, yells out and would refuse to be reposition at times. NA-E also indicated when R32 refuses to reposition, they will go back later, ask her again, and other wise they do not really do anything else for R32. NA-E verified R32 has had her pressure ulcers for a while and stated, "I have never seen them that bad before." On 12/1/16 at 1:00 p.m. NA-F confirmed R32 needed staff assistance with all ADLs and required repositioning by staff every hour. On 12/1/16, at 8:42 a.m. the director of nursing (DON) confirmed R32 currently has two stage 2 pressure ulcer, one stage 3 pressure ulcer and one stage 4 pressure ulcer and has been followed by a wound specialist. DON indicated she felt R32's pressure ulcers were contributed to her poor nutrition, not allowing air mattress and will only lay on one side and not the other side. She added, "Family is aware of her non-compliance." DON indicated the facility discussed the use of mattress overlay on 12/2/15,	F 314		

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with family, which cost $5000.00 and have offered it at every care conference most recently on 11/22/16. She indicated R32 refused the air mattress and confirmed R32 utilized a regular mattress on her bed. DON indicated the facility had not considered other alternatives to a air mattress or alternative wheelchair for R32. DON indicated a ROHO cushion in her wheel chair had been utilized in the distant past but had trouble holding air in the cushion, then changed to a standard cushion for R32's wheelchair. DON indicated she felt a comprehensive assessment was done each week with weekly wound measuring and monitoring of the pressure ulcers. The DON verified R32 was high risk for breakdown and needed to be repositioned every hour as she would comply and would expect staff to approach R32 every hour and follow the care plan as written. DON indicated staff would have to use their own discretion if R32 refused, depending on if R32 was combative or causing her stress we would not re-approach and if she was calm they should re-approach. The DON indicated the facility had attempted several times to contact R32's regular medical doctor as well as her wound specialist and neither have suggested any other interventions. The DON indicated R32's ulcers wax and wane and stated, "This is the worst her bottom has ever been." The DON confirmed R32's physician order for a different wheelchair and stated occupational therapy had assessed R32's wheelchair and they felt there was nothing wrong with her chair. She stated, "We did not change the wheelchair." DON further indicated that she felt there was a communication barrier between the facility, family and medical professionals and stated, "The goals are unclear because of communication." DON indicated if R32 refused to be repositioned every hour, she

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would expect staff to educate R32 on repositioning, reapproach, and staff should be letting the nurse know she does not want to reposition and the nurse should be documenting on the refusal.

On 12/1/16, at 12:32 p.m. per telephone interview, R32's primary physician (MD)-A confirmed R32 had several current pressure ulcers that varied in different stages. MD-A indicated R32 has had decreased mobility, required help with ADLs and should be repositioning frequently, with air mattress in place, padding to her w/c and receiving protein supplements. MD-A indicated he understood staff were implementing R32's interventions and stated he was not aware all of the interventions were not being done. MD-A stated he felt the best thing was to continue to offer the repositioning, air mattress, even if she is not overly interested and stated, "She needs to be repositioned."

On 12/1/16, at 10:53 a.m., family member (FM)-A requested a return phone call on 12/5/16.

On 12/2/16, at 8:40 a.m. during telephone interview, family member (FM)-A stated she routinely visited her mother in the facility and routinely attended medical appointments with her. She stated the wound specialist had requested a different seat for R32's chair but was unaware if R32 had received a new cushion. FM-A indicated the facility got R32 a new bed a few years ago and had tried an alternating air mattress on R32's bed a year ago and it was taken off because R32 did not like it the noise. FM-A indicated the facility talked about a different mattress for R32 bed along time ago, and had discussed how expensive the mattress would be but she did not

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understand the facility was offering to get the mattress. She stated, "I feel they were more concerned about the expense." FM-A indicated the facility staff had not discussed the mattress again with her and felt they did not offer it due to the cost of the mattress. FM-A stated, "[R32] could of paid for it, why they did not look into it more." FM-A verified she attended R32's care conferences on a regular bases. FM-A stated R32 had a care conference last week, but the facility had not notified the family prior and held the care conference without them. FM-A indicated she was not sure how much R32 understands when the facility talks to her at the care conferences. FM-A indicated she feels the care conferences are not informative or effective, they talk about dental, eye appointment, hearing, thing that are not important. FM-A indicated facility staff had not talked about R32's ulcer and what they are going to do different. FM-A indicated the facility had never made any suggestion or come up with any intervention or anything on their own on how to improve R32's ulcers. FM-A also indicated staff just does her dressing and the wound specialist requested a cushion because the bubbles (in ROHO cushion) were not holding air and R32 had a firmer cushion placed on her chair. FM-A indicated R32 sits in her wheelchair a lot during the day, and she has told the facility R32 did not like the lift chair she has in her room but they have not offered anything different and stated "that's why she doesn't sit in it."

On 12/1/16 at 9:26 a.m. a call was placed to the physician identified as the wound specialist (WS). The clinic staff indicated WS was out of the state, would return on the weekend and would return call at that time.

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On 12/5/16, at 9:19 a.m. during return telephone call, WS confirmed R32 had multiple ulcers noted ranging from stage 2 to stage 4 ulcerations on her buttocks areas and hip. WS indicated he felt a lot of the problem was that R32 was wheel chair dependent, and incontinent of urine. WS stated he felt there was conflict between the family and facility and due to the conflict, facility personnel avoided R32's family members and their concerns. WS indicated he had to write very specific orders for the nursing home staff to follow because he does not trust his orders were consistently implemented. WS indicated R32 had ulcers on her right buttocks and left hip that have healed and then reopened. WS indicated he felt R32's pressure ulcers had a lot to do with her not getting out of the wheel chair consistently. WS indicated R32 has chronic pressure ulcer and have been healed in the past but due to constant pressure of sitting in her chair, they have reopened. WS indicated he would expect staff to reposition her consistently and get her up out of her chair. WS indicated for R32's ulcers to heal, staff needed to be "a lot more attentive" or it's not possible to heal her ulcers. He stated he felt staff needed to supervise on daily basis, off loading and providing pressure relief. WS indicated facility staff do not call or communicate with him regarding R32's care and he felt the lack of communication affected R32's pressure ulcer care. WS indicated he felt if there was better communication from the facility, R32 would not be in this situation and stated, "Need to correct communication, lack of communication with continuity of care fails." WS indicated he was aware staff have not been relieving the pressure for R32 and the lack of pressure relief has been a direct cause of R32's ulcers. He indicated he felt her wheel chair should only be used for

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F 314	Continued From page 32 transportation purposes only, otherwise she should be up in her recliner or in bed, not sitting in her wheelchair all day. WS verified he would expect staff to follow R32's interventions to assist in the healing process. Review of facility policy titled, Positioning and Repositioning, undated, indicated to ensure proper positioning and repositioning of residents allowing maximum comfort while minimizing the risk of skin break down, discomfort, pain deformities and /or contractures. Review of facility policy titled, Tissue tolerance, undated, indicated to identify residents at risk for skin breakdown, and care plan length of time they can tolerate a position. Review of facility policy titled, Pressure Ulcer, undated, indicated to ensure necessary treatment and services to promote healing, prevent infection, and prevent new ulcers from developing. Review of facility policy titled, Prevention, Assessment and Treatment of Skin Issues, undated, indicated a pressure ulcer is any lesion caused by unrelieved pressures resulting in damage of underlying tissue, usually occurring over bony prominences. This policy will review specifically the prevention, assessment and treatment of pressure ulcers as well as other skin conditions that require nursing interventions and monitoring.	F 314		
F 325 SS=D	483.25(g)(1)(3) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		1/10/17

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F 325	Continued From page 33 (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify and assess significant weight loss for1 of 3 residents (R15) reviewed for nutrition. Findings include: R15's admission Minimum Data Set (MDS) dated 9/29/16, identified R15 had severe cognitive impairment and required supervision with eating. The MDS further identified R15 was on a regular diet, and had weight loss. R15's Care Area Assessment (CAA) dated 9/29/16, identified R15 had dementia, and an inability to perform activities of daily living (ADL's) without significant physical assistance from staff. The CAA identified R15's had a difficult time understanding others, and making herself	F 325	An assessment was immediately conducted following the survey on 12/07/2016 for resident R15. It was determined that all of the previous interventions that were in place were appropriate and resident will continue to receive this plan: Offer high calorie foods, such as: 1/2 and 1/2 daily with cereal, Extra butter on pancakes, waffles and French toast, and toast. Extra gravy or butter on potatoes. Magic cup, qd. this will aide in adequate nutrition for resident. All residents have the same equal potential to be affected by this specific deficient practice. A policy will be implemented that will allow staff to better monitor a change in a	

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F 325	Continued From page 34 understood. The CAA further identified R15's appetite was poor, and had weight loss. The CAA indicated staff were to closely monitor R15's dietary intake, and cue R15 to eat. R15's care plan, dated 10/11/16, identified R15 's care plan goals were to maintain goal weight of 119# within 5% through 12/29/16. The care plan identified R15 required supervision with eating related to confusion. R15's care plan directed staff to monitor R15's food intake and offer her substitutes if she wasn't eating, and supervise and cue R15 as needed. R15's care plan further identified staff were to refer R15 to occupational therapy (OT) and the registered dietitian (RD) for evaluation and recommendations as needed, and weigh R15 weekly. On 11/30/16, from 12:15 p.m. to 12:55 p.m. R15 was observed seated in her wheelchair at the dining room table, in the back of the dining room against the window. R15 was quiet and continually looked down towards her lap, and appeared very thin. R15 took only bites of her meal (carrot coins, Salisbury steak, mashed potatoes and gravy, pickle, and grapes). R15 struggled to eat and put an empty fork up to her mouth repeatedly, and was unable to get food to stay on her fork. Nursing assistant (NA)-E was seated between R39 and R4 assisting both residents to eat, at R15's table. NA-E asked R15, "Are you going to eat some more of your meat.?" R15 replied, "I'm not hungry." NA-E's walkie-talkie sounded, and she discussed the new admissions across the dining room with NA-F and NA-G, and continued to assist R39 and R4 with their meal. At the end of the meal, NA-E pushed R15's grapes across the table to R15 and asked, "Do you like your grapes?" R15 replied, "I'm full."	F 325	resident□s weights. Upon admission resident will be weighed and a re-weight will be collected the following day on the bath scale to ensure a more consistent weight with the next consecutive weights. The weight will be collected at least weekly or as ordered by the prescriber. The weights will be entered into the system by a licensed staff. If a significant weight gain or weight loss is found it will be reported immediately to the dietary manager. A nutritional assessment will be conducted and the dietitian will be consulted upon any significant weight change and the appropriate interventions will be implemented. The plan of care will then be updated to reflect the findings of the assessment. In addition to the system implemented as above, the dietary manager will review significant weight changes on a weekly basis as provided by point click care. If a significant weight loss or weight gain is noted a nutritional assessment will be conducted and the dietitian will be contacted. The appropriate interventions will then be implemented and the plan of care will be updated. The dietary manager will continue to review residents who have had a significant weight changes quarterly with the quality committee. This will be completed by January 10th 2017.	

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F 325	Continued From page 35 NA-E nodded her head up and down at R15 and repeated back to her, "Your full." R15 had her whole meal in front of her and fiddled with her white paper napkin. NA-E removed her plate and R15 wheeled herself out of the dining room. R15 was not adequately supervised and cued during the meal, and no menu substitutions were offered during this time period. On 11/30/16, from 5:48 p.m. to 6:42 p.m. R15 was observed seated in her wheelchair at the dining room table in the back of the dining room against the window. R15 appeared restless and confused. R15 ate only bites of her meal (ground beef, rice and pepper casserole, mixed vegetables, mandarin oranges and ice cream-like nutritional supplement in a covered, styrofoam container(Magic Cup). R15 picked up her silver teaspoon, examined it and put it back on the table. R15 picked up the magic cup and poked the bottom of the cup with her spoon. R15 tried to tear open the cup, and then picked up her fork and stabbed the container. R15 became frustrated and pushed the magic cup away from her. R15's casserole had large parsley sprigs on top that R15 picked up and put in her mouth. R15 immediately started spitting and took out of her mouth fingers and put on plate. NA-C took the top off the magic cup when she delivered R15's meal and walked away. R15 continued to struggle and try to open the magic cup even after NA-E took the lid off. NA-C was seated at R15's table assisting R4 and R13. R15 struggled to eat her meal with a fork and food fell off the fork onto the table and her lap. R15 stated, "This fork is so dumb you can't work with it." NA-C and R15 laughed. NA-C asked R15, "Is it good.?" R15 replied "I'll manage." R15 continued to struggle	F 325		

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with the magic cup packaging. R15 reached across the table and spilled her bowl of mandarin oranges and R15 and NA-C laughed. Res used a spoon and took a bite of her magic cup and stated out loud, "That's good ice cream." NA-C repeated to R15, "That's good ice cream." R15 took bites of her magic cup with her spoon (consumed approximately 50%), and then filled the rest of the styrofoam cup with her casserole. R15 was not adequately supervised, or cued during the meal, and no menu substitutions were offered during this time period.

Review of R15's Dietary Admission Assessment dated 9/26/16, identified R15 received a regular diet and R15's usual body weight was 138#. The assessment indicted R15 was not able to understand others or was hard of hearing, and had a lot of non-sensical answers to questions. The assessment further identified R15 seemed to need cues and encouragement with eating to stay on task, and dietary would continue to monitor R15.

Review of R15's Nutritional Assessment II dated 9/30/16, identified R15 was on a regular diet, and weighed 119#. The assessment identified R15 was observed to need more cues and encouragement to stay on task during meals and had been moved to the friendship (more dependent on staff) dining room. The assessment further identified R15's meal intake was 25-50%, and R15 had lost 21# since she lived there in 2/2016. R15's interventions included offering high calorie foods, butter added to meals, 4-ounces magic cup per day, and continued monitoring.

Review of R15's weekly weight records identified:

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F 325	Continued From page 37 -R15 had a significant weight loss (significant weight loss is defined as a weight loss of 5% or greater over 30 days, 7.5% loss over 90 days, or 10% over 180 days) of 10.5% of her body weight (12.5#0 from 9/23/16 to 10/12/16 (20 days). R15 weighed 119# on 9/23/16 and on 10/12/16 R15 weighed 106.5#. -R15 was identified to have significant weight loss of greater than 10% of her body weight over the next 7 weeks. Review of R15's meal consumption from 9/23//16 to 11/27/16 identified: -9/23/16 to 9/30/16 R15 had an average meal intake of less than 50% -10/1/16 to 10/31/16 R15 had an average meal intake of less than 50% -11/1/16 to 11/30/16 R15 had an average meal intake of less than 50% Review of R15's progress notes from 9/23/16 to 11/27/16 revealed: -9/29/16, R15 received a regular diet, and had lost 36# or 23% of her body weight since 1/12/16. R15 had inadequate energy intakes due to dementia as evidenced by meal intakes of less than 50% for most meals, and interventions included offer magic cup or nutritional supplement or food of choice to increase calories, may add 2 butter to each meal and other high calorie, high protein foods. Dietary would continue to monitor weight and food intake.	F 325		

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-10/4/16, R15 started eating in the friendship dining room after she was observed to need more cues and encouragement to stay on task. Meal intakes were 25-50%, and current weight was 119#. Staff were to offer hi-calorie foods, add butter to meals, provide 4-ounces magic cup per day, and continued monitoring of R15.

On 11/30/16, at 6:06 p.m. NA-C stated she felt R15 usually ate really good on the evening shift, and stated she didn't know how R15 ate at other meals. She stated she was not aware that R15 had lost any weight. She stated every once in awhile R15 needed encouragement to get started,and stated she did not require any further assistance. She stated interventions included warming R15's food up if it got cold, and a magic cup every night at supper. She stated R15 didn't always eat her magic cup, and stated she felt R15 could benefit from adaptive silverware because her depth perception was not good. She stated R15's favorite foods included ice cream, sweets, potato cheddar soup, and R15 would eat anything if she could put her own salt on at the table.

On 11/30/16, at 6:09 p.m. NA-B stated R15 refused her majic cup about every other night. She stated she felt R15 usually ate less than 50% of her meals, didn't like cold food, and really liked ice cream and sweets. She stated she felt R15 had lost weight, but stated she wasn't sure how much. She stated the magic cup and a glass of beer were the only nutrition interventions she was aware of. She stated she felt R15 could benefit from adaptive, colored silverware, and stated she felt R15's depth perception was bad and R15 fed herself.

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F 325	Continued From page 39 On 11/30/16, at 6:46 p.m. NA-A stated R15 ate an average of about 50% of her meals. He stated R15 received a magic cup. He stated he felt if someone sat next to R15 it would help her eat better. He confirmed no staff sat next to her for meals, and R15 fed herself. He stated he thought the only nutrition intervention for R15 was the magic cup. On 11/30/16, at 6:56 p.m. director of nurses (DON) stated resident weights are monitored daily or weekly and entered into their computer system. She stated the computer program would alert staff of significant weight loss after they entered a resient weight in the sytem. She stated the NA would alert the nurse immediately of the weight loss, the nurse would notify the food services director (FSD) immediately, and the FSD would contact the consultant registered dietitian (RD) immediately to complete a comprehensive nutritional assessment within 1 week. DON confirmed R15 had poor food intake and confirmed r15's significant weight loss. DON confirmed R15's most recent nutrition assessment was 10/4/16. She confirmed nutrition interventions included a magic cup, and adding butter to meals or other high calorie foods. She stated she expected staff to follow there process to identify, and assess significant weight loss, and it was not followed. She stated she also expected staff to develop and follow R15's care plan. On 12/1/16, at 1:50 p.m. FSD confirmed she was not aware of R15's eating problems or significant weight loss. She confirmed R15's last nutrition assessment was completed 10/4/16 by the RD. She stated she thought when the bath aide entered R15's weight, she missed the alert which	F 325		

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identified R15's significant weight loss. She also stated she could track resident weight loss on the computer herself, but didn't know how to do that. She stated a comprehensive nutritional assessment was only done on admission, and with each MDS. She stated she did not routinely assess residents with significant weight loss outside of MDS assessments.
She stated R15's weight loss should have been identified sooner and interventions put in place. She confirmed R15's nutrition interventions included a magic cup, beverage or food of choice, staff may add 2 butters to each meal or other high calorie, high protein foods. She stated after the RD assessed R15, she was responsible for implementing recommended interventions, and stated she wasn't sure if the interventions were being done.
FSD stated R15's food intake averaged 50-75%, and R15 had a few meal intakes of about 25%. She confirmed the facily had not recorded R15's intake of the magic cup. She stated if R15 wasn't eating well, she expected staff to offer her menu substitutes, encourage and cue her and report changes to the nurse. She stated if she had been aware of R15's signicifant weight loss she would have referred R15 to the RD and OT.
She stated she expected staff to follow R15's care plan, and they didn't. She confirmed R15's care plan failed to identify all of the RD's recommendations and interventions. She stated resident nutrition care plans were only reviewed and revised quarterly at the time of the MDS.
Review of the facility policy, "Weight Management," identified the dietary manager would keep track of all weights and compare weight loss, and if there is a 5% weight loss in 1 month, or a 10% weight loss in 6 months, the dietary manager would address it and put

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F 325	Continued From page 41 appropriate interventions in place, family and physicians would be informed, and a plan of care developed to address target areas for improvements and to set goals.	F 325		
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review the facility failed to ensure medication was administered as ordered to prevent significant medication error for 1 of 10 residents (R25) observed for medication administration. Findings include: Review of R25's Minimum Data Set (MDS) dated 9/15/16, identified R25 had diagnoses which included asthma and acute respiratory failure and had intact cognition. On 11/28/16, at 4:29 p.m. licensed practical nurse (LPN)-A removed a oral inhaler for R25 which was labeled, Symbicort (inhaled medication used to treat asthma) 80-4.5 microgram/actuator (mcg/act) 2 puffs twice daily (bid.) LPN-A compared the pharmacy label on the Symbicort to the physician order in the (electronic medication administration record (MAR). LPN-A checked off the medication on the MAR, indication medication was in the process of administration. She then walked down the hall to R25's room, entered and administered 2 puffs of Symbicort 80-4.5 mcg/act to R25 and left R25's room to return to the	F 333	Corrective action was accomplished immediately by following the medication error process. The doctor was notified and the order was clarified. The order now reflects the medication that the resident is receiving. A full reconciliation was completed by the Director of Nursing for this resident and no other medication discrepancies were found. Upon re-admission from the hospital a medication reconciliation will be performed and staff will verify the medication and ensure the Rx label matches the medication administration record. A mandatory in-service will be conducted by the consulting pharmacist that will include but not limited to; the basic guidelines of medication administration, focused review of medication administration of an inhaler, what a medication error classified as, how medication errors are found including medication reconciliation, what to do when a medication error is found, and	1/10/17

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F 333	Continued From page 42 medication cart. LPN-A then documented in R25's MAR the Symbicort had been administered. On 11/28/16, at 5:30 p.m. LPN-A confirmed she had given R25 Symbicort 80-4.5 mcg/act and confirmed R25's physician order identified an order for Symbicort 160-4.5 mcg/act. LPN-A stated the usual practice was to compare the order written on the MAR to the order written on the label of the medication. LPN-A stated if the medication supplied and the order in the MAR were not the same, she should not give the medication. Review of R25's physician orders signed 10/20/16 for R25, included an order for Symbicort 160-4.5 mcg/act inhale two puffs orally two times a day (BID), with a start date of 9/16/2015. On 11/28/16 at 5:59 p.m. The director of nursing (DON) was notified of the discrepancy between R25's physician order and the medication that had been administered. The DON contacted the pharmacy by phone at that time and stated the pharmacist had confirmed the pharmacy had always sent Symbicort 80-4.5 mcg/act dosage to the facility for R25. On 11/30/16, at 5:20 p.m. LPN-B stated the usual facility practice was to compare the dosage of the medication provided with the order on the MAR, if the dosages did not match she would not give the medication until the order was clarified. On 12/1/16, at 11:30 a.m. during a phone interview Pharmacist (P) confirmed the pharmacy had always sent Symbicort 80-4.5 mcg/act to the facility for R25 since August 2015. He stated the	F 333	procedure of medication errors. This will also be added to our orientation checklist for staff who are administering medications. Medication administration audit will be conducted by the Director of nursing weekly X 12 weeks. The findings of the medication audits and a review of the quarterly medication errors will be discussed in the quarterly quality meetings. Changes will be implemented as needed. This will be completed by January 10th 2017.	

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pharmacy had not been notified of an order for Symbicort 160-4.5 mcg/act dated 9/16/15 until 11/28/16 when the DON called. Pharmacist stated he expected the facility to notify the pharmacy immediately of any discrepancies between any medication supplies and orders to ensure correct dosage of medications were given to residents.

On 12/1/16, at 12:12 p.m. during follow up interview the DON stated she expected nursing staff to follow facility policy and to verify the medication dosage and the order were accurate. DON stated licensed staff were orientated to the facility medication administration practices and she stated she expected staff to follow facility policy.

On 12/2/16, at 12:20 p.m. during a phone interview with R25's primary physician (MD) stated he had not been aware R25 had been incorrectly been administered Symbicort 80-4.5 mcg/act until 11/28/16. He confirmed the correct medication order R25 was to receive was Symbicort 160-4.5 mcg/act dosage not the 80-4.5 mcg/act dosage. He stated R25 had experienced repeated asthma exacerbations in the past and felt it could be related to the lower dose of Symbicort he had received in error. MD stated he expected facility staff to ensure residents received the correct dosage of medication during medication administration pass.

Review of R25's monthly (MAR)s from February 2016, to November 2016, revealed each monthly MAR and order for Symbicort (Bedesonide-Formoterol Fumarate) 160-4.5 mcg/act inhalation two puffs two times a day. Further review of the monthly MAR's revealed

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EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(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 333	Continued From page 44 that all entries of the Symbicort 80-4.5 mcg/act had been signed off as administered. Review of Physician progress from 2/5/16, to 10/20/16 revealed the following; -2/5/16, revealed R25 had a diagnosis of asthma/chronic obstructive pulmonary disease and had a recent asthma exacerbation. The note revealed R25 had been hospitalized earlier that year with intubation and need to monitor his reactive airways closely. Documentation indicated medication orders were reviewed and updated, which included an order for Symbicort 160-4.5 mcg/act 2 puffs BID. -5/23/16, revealed R25 had a diagnosis of asthma, R25's medication orders were reviewed and updated, which included an order for Symbicort 160-4.5 mcg/act 2 puffs BID. -7/21/16, revealed R25 had a diagnosis of asthma/chronic obstructive pulmonary disease (COPD.) The note revealed R25 had been hospitalized within the last several months for asthma exacerbation, which had required intubation. The note also revealed R25's medication orders were reviewed and updated, which included and order for Symbicort 160-4.5 mcg/act 2 puffs BID. -10/20/16, revealed R25 had a diagnosis of asthma/chronic obstructive pulmonary disease, including a history of exacerbations. The note revealed R25 had required an additional respiratory medication to manage asthma/COPD symptoms. The note further revealed R25 was to continue to receive Symbicort 160-4.5 mcg/act 2 puffs BID.	F 333		

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F 333	Continued From page 45 Review of R25's progress notes from 2/24/16, to 11/21/16, revealed the following; -2/24/16, R25's physician had been notified regarding R25 had been short of breath and had audible wheezing while breathing. -2/25/16, R25's physician had ordered prednisone (a steroid medication used to treat acute asthma exacerbations.) - 3/21/16, revealed R25's physician had again ordered prednisone. -4/11/16, revealed R25's physician had been notified regarding R25 had been short of breath and had required use of nebulizer treatments. The note also indicated R25 had also been receiving Symbicort Aerosol 160-4.5 mcg/act. -4/12/16, revealed R25 had a new medication singular (medication used to prevent asthma exacerbations.) -4/19/16, revealed R25 had complained of shortness of breath. -4/19/16, revealed R25's physician had ordered prednisone to treat shortness of breath. -4/22/16, revealed R25 had been transported to the emergency room via ambulance due to shortness of breath. -4/24/16, revealed the facility nurse had been informed R25 had been admitted to the hospital for an asthma exacerbation. The note further revealed R25 was in intensive care unit, had been	F 333		

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F 333	Continued From page 46 intubated and was on a ventilator. -4/30/16, revealed R25 had returned to the facility from the hospital. -7/5/16, revealed physician had been notified R25 had shortness of breath and audible expiratory wheezes. -7/6/16, revealed R25's physician had ordered prednisone to treat shortness of breath. -8/8/16, revealed R25's physician had been notified R25 had been wheezing and had an increased respiratory effort. The note revealed a physician order had been received for prednisone to treat the symptoms. -9/2/16, revealed a physician order had been received for prednisone for R25. -11/21/16, revealed the physician had been notified R25 had shortness of breath. The note revealed a physician order had been received for prednisone to treat the symptoms. A facility policy for medication administration and prevention of medication errors was requested, none was provided.	F 333		

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2016**

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EVANSVILLE CARE CENTER	**649 STATE STREET NORTHWEST** **EVANSVILLE, MN 56326**

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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 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 YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Evansville 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 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2016

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

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K 000	Continued From page 1 and Angela.kappenman@ state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Evansville Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1968 and was determined to be of Type I(332) construction. In 1988, additions were added to the south of the Main Lounge and to the west of the North Wing that were determined to be of Type V(111) construction. In 1998 and addition was added to the end of West Wing that was determined to be of Type V(111) construction. Because the original building and the additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The facility is completely fire sprinkler protected. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 32 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by:	K 363		1/1/17

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K 363	Continued From page 3 Based on observation and staff interview the facility failed to provide two corridor doors with a means suitable for keeping the door closed and resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 21 of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 12:30 pm on 11/30/2016 observations and staff interview revealed two linen closets, one next to resident room 122 and one next to resident room 102 that did not positively latch and are not able to resist the passage of smoke. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 363	Tag 0363 The two linen closet doors have been repaired with an improved magnetized closing system. The doors have been readjusted. The closing gap has been affixed with a metal strip overlap keeping the doors securely closed when not in use and resist the passage of smoke in accordance with the 2012 Life Safety Code. Completion date is 1/1/2017 Maintenance Man Brad Rosten is responsible. Maintenance Man will conduct monthly inspections and log results to assure ongoing compliance.	
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		1/1/17

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K 372	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of three smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 11 of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 12:30 pm on 11/30/2016 observations and staff interview revealed a penetration in the east wing smoke barrier above the ceiling line approximately 12 inches by 8 inches. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 372	K0372 3M Fire Pillow will be applied to the 12 inch by 8 inch penetration area above the ceiling line of the east wing smoke barrier. This will seal the area to prevent the transfer of smoke from one compartment to another as required by the 2012 Life Safety Code. Completion date 1/1/2017 Maintenance Man Brad Rosten is responsible. Maintenance Man will conduct monthly inspections and log results to assure ongoing compliance.	