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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 7FPW
Facility ID: 00611

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245012**

2.STATE VENDOR OR MEDICAID NO.
(L2) **395040900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUARDIAN ANGELS CARE CENTER**
(L4) **400 EVANS AVENUE**
(L5) **ELK RIVER, MN** (L6) **55330**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **7/17/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **120** (L18)
13.Total Certified Beds **120** (L17)

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

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
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 07/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/19/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1967
(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

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245012
July 18, 2018

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

Dear Ms. Spiers:

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 July 6, 2018 the above facility is certified for:

120 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 120 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

Electronically delivered
July 18, 2018

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: Project Numbers S5012029, H5012026, H5012027

Dear Ms. Spiers:

On June 11, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective June 16, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 12, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on May 24, 2018 that included an investigation of complaint numbers H5012026, H5012027. 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 July 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 10, 2018 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 May 24, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 6, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 24, 2018, as of July 6, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 6, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter from June 11, 2018:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective August 12, 2018 be rescinded as of July 6, 2018. (42 CFR 488.41(a)).

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and

appeal rights.

In our letter of June 11, 2018, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 24, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 6, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

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(L4) **400 EVANS AVENUE**
(L5) **ELK RIVER, MN** (L6) **55330**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/24/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)

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2 AOA 3 Other

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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To (b) :

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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
	120			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Bruce Melchert, HFE NE II 07/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/18/2018 (L20)

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

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____ 2. Facility is not Eligible
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01/01/1967
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

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(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
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07-Provider Status Change
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28. TERMINATION DATE:
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29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

June 11, 2018

Ms. Julie Spiers, Administrator
Guardian Angels Care Center
400 Evans Avenue
Elk River, MN 55330

RE: Project Numbers S5012029, H5012026, H5012027

Dear Ms. Spiers:

On May 24, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the May 24, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5012026, H5012027, which were found to be substantiated. 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 electronically delivered CMS-2567, whereby corrections are required.

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
>
> Appeal Rights - the facility rights to appeal imposed remedies;
>
> 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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective June 16, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 12, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective August 12, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 12, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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, Guardian Angels Care Cente is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 12, 2018. 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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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 August 24, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies 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
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE** **ELK RIVER, MN 55330**

(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
E 000	Initial Comments A survey for Centers for Medicare and Medicaid (CMS) Appendix Z Emergency Preparedness Requirements, was conducted on May 21-24, 2018 during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		7/2/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/20/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING ______ B. WING ______	C 05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE** **ELK RIVER, MN 55330**

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E 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041		

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E 041	Continued From page 2 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not provide an essential electrical system in accordance with NFPA 99 (2012) Health Care Facilities Code and NFPA 110 (2010) Standard for Emergency and Standby Power Systems. This had the potential to affect all residents residing in the facility. Findings include: During an inspection of the facility on 5/23/18, from 8:30 a.m. until 1:00 p.m. the Fire Marshall with the director of environmental services (DES) and facility administrator (ADM) identified the facility did not have a remote emergency shutdown switch for the outdoor emergency	E 041	Remote emergency shut switches have been installed on the outdoor emergency generators. Emergency Plan was reviewed and updated regarding the addition of the switches. Quarterly monitoring to ensure switches are intact has been added to our preventative maintenance program. Results will be communicated in QAA meeting. Maintenance Director will be responsible for this.	

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E 041	Continued From page 3 generator located outside of the containment unit. On 5/24/18, at 2:45 p.m. ADM stated that the facility was unaware of this change to the life safety code. ADM stated that DES has already contacted the generator company for the installation of the remote emergency shutdown switch.	E 041		
F 000	INITIAL COMMENTS A recertification survey was conducted May 20, 2018 through May 24, 2018, by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. At the time of the survey, investigations of complaints #H5012026 and #H5012027 were completed and both were found to be substantiated with deficiencies cited at F550, F609, F610. 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		7/2/18

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F 550	Continued From page 4	F 550		

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the

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F 550	Continued From page 5 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide dignified treatment for 2 of 2 residents (R8 and R59) who received unrequested perineum grooming and lacked cognitive capacity to consent to this provision of care. In addition, the facility failed to ensure a thoracic brace was worn and labeled in a dignified manner for 1 of 1 resident (R91) who used a thoracic brace. Findings include: R8's diagnoses, as identified on the resident Admission Record face sheet, printed 5/24/18, included Alzheimer's disease (a type of dementia). A significant change Minimum Data Set (MDS) dated 2/6/18 indicated R8 had severely impaired cognition. R8's Investigation Summary report, submitted to the State Agency dated 5/8/18, indicated: On April 20, 2018, registered nurse (RN)-D received report that a resident, R8, was found to have had pubic hair removed. The report indicated nursing assistant (NA)-P told RN-D she shaved R8's pubic area, secondary to reports of pain and tugging on pubic hair during cleansing following fecal incontinence episode. The report further indicated NA-P asked R8 if she would allow her to do shaving, and R8 responded affirmatively. The report indicated RN-D provided verbal counseling to NA-P and instructed her not to shave perineum of residents, that this was out of the scope of the nursing assistant's practice, and also that R8 was unable to give consent.	F 550	R8, R59 - Training was completed with staff following discovery of perineal shaving. Training included no further residents were to have perineal shaving. R91 - Labels for the TLSO brace have been moved to the inside of the brace. Braces of all types have been checked for markings that could be considered undignified. No further markings have been found. Training will be done with all current staff regarding issues with perineal shaving and markings on braces by 7/2/18. Information regarding no perineal shaving has been added to orientation for all new staff. Each resident will be checked for pubic hair shaving as part of his/her weekly skin check. Documentation of checks will be made. NUM and DON will be notified immediately if any perineal shaving noted-findings will be reported to OHFC. All new residents admitted with braces will have braces inspected at time of admission to ensure labeling is not visible, PT, OT, & NUM will monitor all braces weekly to ensure no markings added to exterior of brace. Findings will be reported at the QAA Meeting every 2 months.	

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When interviewed on 5/21/18 at 10:18 a.m., nursing assistant (NA)-E stated the shaving of a "peri-area" (perineum) was not something nursing aides would do, and also that it would be "unprofessional and not acceptable." NA-E stated she had never heard of anything like that and were never trained to do something on a whim like that. NA-E stated the shaving was "unprofessional conduct" and a "lack of knowledge" by the aide.

When interviewed on 5/21/18 at 10:26 a.m. nursing assistant (NA)-C stated what happened with R8 "was totally inappropriate" and the shaving of the peri area was not at all dignified. NA-C stated family member (FM)-B "started crying in front of me" when she learned what happened to her mother.

When interviewed on 5/21/18 at 6:34 p.m. family member (FM)-B stated when she learned her mother's perineum had been shaved by a nursing assistant "I felt horrible, and it made me want to cry knowing someone did that to my mother." FM-B stated she learned the reason the shaving was done was for "cleanliness", and added "I'm sorry, but shaving someone in that area can cause other problems. Something is not right." FM-B questioned how a nurse aide could take that upon herself and do that. FM-B stated this was not anything like "dignity," and added, "it's beyond that, something is wrong."

When interviewed on 5/22/18 at FM-A stated nothing had been explained to us. FM-A stated she realizes her mother has dementia, but in the moment R8 knows what's going on. FM-A stated R8's dignity was taken away "at the very least"

F 550

Nurse Unit Managers will be responsible for this.

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F 550	Continued From page 7	F 550		

and at the end "we don't know what really happened; that was my mother, a defenseless, ninety-one year old." FM-A stated nothing had been explained to us. FM-A stated the practice of wanting to be shaved was something my mother "would not have wanted." FM-A stated (R8) was not capable of making that choice, and there was no way she requested that to be done. FM-A stated "we did not have a say" in making that part of her care plan.

R59's quarterly MDS, dated 4/3/18, indicated moderate, cognitive impairment.

R59's facility Investigation Summary report sent to the State Agency on 5/7/18, indicated: On April 30th nursing assistant staff noted a second resident had been shaved in the perineum area. The report indicated NA-P reported that she shaved R59. The report indicated R59 had asked for legs to be shaved earlier in the week during a shower. NA-P was unable to complete the task then, but offered to shave R59 on the night shift of April 29th into April 30th. The report indicated R59 wished to be shaved and agreed to having her perineum shaved secondary to incontinence episode and hygiene needs.

When interviewed on 5/20/18, at 6:42 p.m. nursing assistant (NA)-D stated it would not be usual practice to shave a resident's personal or private areas. NA-D stated if a resident who is not able to give consent, was shaved "down there" would be wrong, and it may be against what the resident believes, and would be "undignified." NA-D stated this was something that was "just not done." NA-D also stated R59 was dependent upon staff for her activities of

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F 550		F 550		

Continued From page 8
daily living (ADL) needs, and also stated she did not think R8 was able to give consent completely on her own, especially to be shaved.

When interviewed on 5/22/18, at 9:54 a.m. family member (FM)-C stated R8 was "kinda slow" about making decisions, some days she can make them, other days "she really can't." FM-C stated that if you would ask R8 if it would "Ok" to do this, "She would shake her head and agree to anything." FM-C stated he did not think shaving [R8's] private area was "a usual practice" for the nursing home, and added "I don't think it was something she would normally have had done." FM-C stated the nursing home called and then later personally informed him (R59's) perineum had been shaved "after it happened."

During interview on 05/22/18, at 1:46 p.m. RN-D stated the shaving of the peri areas "was not" a usual practice in the nursing home. RN -D stated she felt it goes back to the aide's intentions, and the aide was trying to do good to the residents. RN-D stated it was not acceptable treatment of residents, to do something for which they have not asked or have given consent.

When interviewed on 5/23/18, at 3:31 p.m. the director of nursing (DON) stated if there was a resident incident, families should be updated immediately. The DON acknowledged and stated regarding to the lack of timely notification, with regard to the perineal grooming, was not good customer service to our family, and we could have done better. The DON also stated it would have been good customer service to update the families, and "we failed on that."

The facility Investigation Summary report sent to

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F 550	Continued From page 9 the State Agency on 5/7/18 for R8 and R59's , indicated:that NA-P "was coached on generation-sensitive interventions, that although this is currently accepted practice among millennial [perineum shaving] it is not common among seniors and may be unwelcome." R91's admission MDS dated 5/1/18, identified severe cognitive impairment and the need for extensive assistance for dressing. A diagnosis of Alzheimer's disease was identified. During observation on 5/20/18, at 5:12 p.m. R91 was seated in the dining room for the evening meal. A black thoracic brace was fastened to her chest. There was a piece of tape labeled top at the top of the brace and a piece of tape labeled bottom at the bottom of the brace. R91 had an open jacket and the labels were visible. During observation of morning cares on 5/22/18, at 7:07 a.m. NA-K fastened the black thoracic brace onto R91's chest. A open faced jacket was then placed on R91 and she was brought to the dining room. The top and bottom tape labels were visible. On 5/24/18, at 9:00 a.m. R91 was seated in her recliner she had the black thoracic brace on, with the top and bottom labels on the brace and were visible from the door. At 9:05 a.m. RN-F stated therapy placed the tape on the thoracic brace so staff put it on correctly. RN-F stated it should have been placed on the inside of the brace so it was not visible to others, as it was a dignity issue. During interview on 5/24/18, at 10:28 p.m. RN-G stated the visible tape on R91's thoracic brace was a dignity issue and a reasonable person	F 550		

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F 550	Continued From page 10 would not have labels showing. When interviewed on 5/24/18, at 1:49 p.m. the DON stated the tape on the thoracic brace was placed by therapy. The DON stated although, it could be a dignity issue, she did not view it as such, as it was placed on medical equipment and not on her clothing. A policy regarding resident dignity was requested, but none was provided.	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to accommodate resident needs to promote independence with bed mobility for 3 of 3 residents (R48, R51,R110) who became more dependent after removal of side rails. In addition the facility denied 1 of 1 resident (R111) request to store hygienic products for personal care use in a shared bathroom with her roommate. Findings include: SIDE RAILS R48's quarterly Minimum Data Set (MDS) dated 3/27/18, indicated she was moderately cognitively	F 558	R48, R51, R110 will be evaluated by the interdisciplinary team including PT/OT to determine reasonable accommodations available and appropriate for resident use. Each resident will be asked if he/she desires a bed rail. If yes, the IDT will perform an assessment for grab bar use. Depending upon the assessment findings, residents may be provided bed rails or alternatives necessary for reasonable accommodation. These residents will be reassessed each quarter and PRN for need. Assessment tool developed Nursing:	7/6/18

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F 558	Continued From page 11 intact Impaired and needed extensive assist of one with bed mobility. R48's care plan dated 2/23/28, indicated she was able to off load independently in bed and chair and was able to request for assistance when needed. R48's Diagnosis/History report indicated she had major depression and history of pain in shoulder, hip and knee. On 5/22/18, at 9:15 a.m. R48 was observed to be sitting in her Broda wheelchair (tilt and space wheelchair) next to her bed. The bed had no side rails and was against the wall. During interview 5/22/18, at 9:24 a.m. R48 stated that her side rails were removed approximately six months ago and it felt like forever. R48 stated the facility stated it was mandatory to remove them and it was a state ruling. R48 then stated "Apparently they haven't slept in these beds to see what it is like to get out of bed once you are in them!" R48 then stated sometimes I have coughing/choking bits and I don't know if I should hit the wall or the floor because I don't have a rail to grab onto. She then stated "this is for the birds." During interview 5/23/18, at 1:09 p.m. the facility director of nursing (DON) stated the facility did remove the side rails due to the new regulations and they did have therapy evaluate some of the residents that had concerns and offered them a trapeze bar if needed. During interview 5/23/18, at 2:54 p.m. the DON stated R48 can reposition herself without the side rails and that she has had no falls out of bed from coughing or hitting the wall and that her mobility had not been effected by the removal of the side	F 558	Evaluation for Use of Grab Bars. Staff will be trained on assessment and policy and procedure for use. Bathroom shelves have been ordered to allow residents in double rooms on the 300 wing to store items in bathroom - other units have medicine cabinets and are not affected. The shelves will be installed in all 300 unit shared bathrooms. 100% facility audit to be completed by July 2, 2018 to ensure all residents have been queried regarding desire for bed rails and assessed if so needed. Weekly audits will be conducted of 10% of residents, to ensure reasonable accommodations have been met consistent with resident needs. Findings will be reported at the QAA meetings every 2 months. Nurse Unit Managers will be responsible for this.	

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F 558	Continued From page 12	F 558		

rails.

During interview 5/23/18, at 3:09 p.m. nursing assistant (NA)-M stated they need to help turn and wiggle R48 into bed and adjust her feet and head and when she needed to sit up they make sure her feet are on the floor and help her sit up. NA-M stated that R48 had expressed to her that she wanted her side rails back. NA-M then stated R48 had been able to transfer herself into bed with the side rails and now needs help from nursing assistance where in the past she had not.

During interview 5/23/18, at 3:15 p.m. registered nurse (RN)-H stated she was aware that R48 wanted her side rails back and that they offered her a trapeze bar to assist with her mobility but she refused that.

During interview 5/24/18, at 9:36 a.m. NA-N stated R48 needed extensive assist to sit up due to pain in her right leg and had mentioned multiple times she wanted her side rails back. NA-N then stated she would use the rails for mobility when she had them and there were multiple residents upset that the side rails were removed. NA-N stated they were told they took them away because someone got hurt at a different facility from the rails so we were told we cant have them here.

During interview 5/24/18, at 9:49 a.m. physical therapist (PT)-A sated the facility removed all of the residents side rails and that she was asked to evaluate some of the residents that had concerns regarding the removal of the side rails to see if there were other options. PT-A stated she suggested to those to park their wheelchair next to the bed so they could use as an artificial side

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rail or offering a trapeze bar for mobility. PT-A stated she was not asked to evaluate R48.

R51's quarterly Minimum Data Set (MDS) dated 3/30/18, identified R51 had a moderate cognitive impairment and received extensive assistance to turn and reposition while in bed. R51's medical diagnoses included a neurodegenerative disorder which affected his physical ability to move.

On 5/22/18, at 8:04 a.m. R51 was observed getting up from bed. The head of his bed elevated to a 90 degree angle and R51 stated this was necessary for him to get up from bed. R51 stated he wished to speak to someone about the "State" telling the facility they couldn't use bed rails in the facility as he felt they were helpful and allowed him increased independence with repositioning.

R51's care plan revised on 4/21/18, identified a self care deficit with activities of activities of daily living (ADL's) related to his neurodegenerative disorder and a history of syncope (fainting) with falls. The care plan directed staff to encourage R51 to participate to the fullest extent possible, and to monitor for any changes, reasons for self care deficit, and decline in function. The care plan identified R51 was able to able to offload his heels, but failed to identify R51's ability to turn and reposition while in bed.

On 5/24/18, at 2:46 p.m. nursing assistant (NA)-O stated R51 used the side rails to help him roll from side to side. NA-K stated R110 used the side rails "a lot' to aide in turning and repositioning.

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R110's quarterly MDS assessment dated 4/26/18, indicated R110 had moderate cognitive impairment and required assistance with turning and repositioning /bed mobility. R110's medical diagnoses included osteoarthritis, chronic pain, fibromyalgia (a disease which affects muscles and soft tissues) and osteoporosis (a condition of fragile bones with an increased susceptibility to fracture).

R110's care plan revised on 2/21/18, indicated R110 had a self care deficit with ADL's related to arthritis, fibromyalgia, and weakness. The care plan indicated R110 was able to off-load (relieve pressure) independently while in bed. Staff were directed by the care plan to encourage resident to participate in activities which promoted exercise, physical activity for strengthening, and improved mobility.

On 5/21/18, at 10:06 a.m. R110 stated she had previously had side rails in place on her bed and thought the rails were helpful to assist her in repositioning. R110 stated the rails were removed as a "State" call, adding she felt this was "bad" as we have "nothing to support us" and we "can fall easily".

On 5/24/18, at 2:46 p.m. NA-O stated R110 had used her side rails to aid in turning and repositioning and reported R110 required increased assistance from nursing staff since rails are no longer available.

On 5/23/18, at 9:04 a.m. the director of nursing (DON) stated the facility had removed all side rails from residents beds as they were felt to be a

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restraint. The DON stated the facility utilized physical therapy (PT) to complete an assessment to determine potential for alternate interventions.

However, there was no indication in the residents records that a PT assessments were completed for R48, R51, R110 to determine positioning needs, or if a device was needed to assist the resident to maintain their highest level of function for bed mobility.

On 5/24/18, at 12:04 p.m. physical therapist (PT)-A stated when the side rails were removed from the facility some courtesy screenings were performed for the residents who were "persistent complainers". PT-A stated there were no formalized assessments or documentation completed, adding the screening was performed to see if the resident would benefit from the use of trapeze. PT-A stated R48, R51, and R110 were not assessed by therapy for alternatives to side rails.

On 5/24/18, at 2:15 p.m. licensed practical nurse (LPN)-E stated residents who could move more independently with the use of the side rails were more upset with the removal of side rails as they could move more freely with the use of the siderails to reposition. LPN-E stated the use of the side rails allowed residents increased independence with repositioning and would allow them to alleviate the pressure. LPN-E stated R51, and R110 would benefit from the use of side rails, adding the use of rails allowed residents to aide in repositioning.

A policy for side rail use was requested but was not provided.

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STORED HYGIENIC PRODUCTS

R111's annual MDS dated 4/28/18 identified she was moderate cognitive impairment, and needed extensive assistance with activities of daily living.

On 5/21/18, at 9:05 a.m. R111, stated the facilty will not allow her to keep her personal hygiene incontinence wipes she uses for personal hygiene in her bathroom whom she shares with one roommate, as it was a "state requirement." Resident was told she needed to keep her personal care wipes with her in her wheelchair. R11 stated she attempted to keep the products in her chair, but the package leaked and caused her clothing and cushion to become wet.

R111's care plan dated 4/6/18, identified problems with incontinence of bowel and bladder and decreased mobility. The care plan indicated R111 required assist of staff for toileting, but identified R111 does self transfer at times.

During interview on 5/23/18, at 3:47 p.m. RN-H stated she was aware R111 wished to leave the personal hygiene wipes in the bathroom but was unable to do so related to potential infection control concerns. RN-H stated R111 was instructed to carry them with her so the product would be available.

A policy was requested for storage of personal items in a shared area was requested but was not received.

F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	F 600		7/6/18

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§483.12 Freedom from Abuse, Neglect, and Exploitation
The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure each resident was free from abuse for 1 of 3 residents (R85) reviewed for abuse. This resulted in actual, psychosocial harm when R85 was threatened to be video taped by staff causing behaviors of increased yelling, screaming, and making new comments of staff were not nice and suicide comments which she had not exhibited before this staff's action. R85 was sent to psychiatric hospital due these escalating behaviors.

Findings include:

R85's admission Minimum Data Set (MDS) dated 3/26/18, indicated she was moderately cognitively impaired, no behaviors and needed extensive assist from staff for activities of daily living (ADL)'s. R85's Admission Record undated indicated she had adjustment disorder, injured in unspecified motor vehicle accident with multiple

Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility¦ s allegation of compliance.

Identified staff member is no longer employed at GACC.

All staff members will be retrained on resident rights, vulnerable adult and elder justice act. Training will also focus on specific example provided in survey.

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fractures. R85's Care Area Assessment (CAA) dated 2/22/18, indicated mood and behavior did not trigger for assessment.

R85's care plan dated 4/09/18, indicated she admitted to the short term rehab area in the facility secondary to motor vehicle accident (MVA) and was previously living at home. The care plan further indicated R85 was at risk for abuse by others related to potential inability to remove self from harm, limited mobility related to MVA with multiple injuries. The care plan directed to follow facility guide lines for reporting injury or harm to the resident. In addition, the care plan indicated she had a behavior problem of yelling out/screaming inappropriately in resident areas and room, putting herself on the floor from bed and profusely yelling at staff. Staff were directed to provide opportunity for positive interaction attention, stop and talk in passing as able.

R85's Associated Clinic of Psychology report dated 2/14/18, indicated she was seen for evaluation of her mood. The report indicated she had mild irritability, agitation and anger and had no suicidal nor homicidal ideation. The report recommended her to benefit from staff support, kindness, patients and reminders that she is well liked. R85 was seen again on 4/11/18, for adjustment disorder with depressed mood. The report indicated she would benefit from staff kindness, patience, support and reminders she is a valuable member of the community. Lastly R85 was seen on 4/30/18, which indicated she had behaviors of screaming and crying out, sometimes at night and throwing herself out of bed. The report recommended staff kindness and support, staff take turns working with her and support each other and her distress is related

Policy and procedure for vulnerable adults was reviewed, and remains current and up to date.

All staff will be aware of and monitor for any episodes of abuse or neglect and report immediately to the Administrator and the Director of Nursing. Staff will attest, daily, to the fact that they have reported any potential episodes of abuse or neglect.

There will be a 100% audit of these forms 5 days a week to ensure compliance. The results of this audit will be shared every 2 months at the QAPI meeting. All vulnerable adult incidents/reports will be reviewed every two months at the QAPI meeting.

Administrator, Director of Nursing and Director of Social Services will be responsible.

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F 600	Continued From page 19 primarily to pain, frustration with slowness of her healing. The report indicated she was on trial of Celexa (antidepressant) and was being discontinued due to lack of symptom improvement and family member (FM)-A reluctant to have her start on medications that may have side effects that would exacerbate difficulties with her bowels. The report indicated she had no suicidal or homicidal ideations. Review of facility Progress Notes on 5/09/18, at 14:43 p.m. R85 was heard yelling out from down the hall. Resident's nurse (unknown) reported resident had been yelling out for approximately 20 minutes and not able to be calmed down or redirected with 1:1 discussion. FM-A was called by staff to see if talking to FM-A would calm her down, however, she continued to scream. Resident had asked maintenance staff member for a scissors during this time of yelling out with no reasoning. Writer approached resident and asked to visit, resident immediately escalated stating, "Are you on their side? I'm going to walk out of here, I'm just going to have to commit suicide." Resident then continued to scream not letting writer get any words in for comfort. At that time a therapist approached to talk with resident and writer went to medical doctor (MD) and social worker (SW) to discuss a plan. Writer communicated resident's comment of suicide. Per Unity Psych Unit, we were advised to send to Unity emergency room (ER) for admit to psych unit due to escalating behaviors and risk for self harm. Progress note 5/9/18, at 15:04 p.m. indicated R85 was yelling to call the police to report they kidnapped her daughter, she had just finished talking to her on the phone. During the morning	F 600		

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when aide was helping patient get up, resident grabbed the aide's shirt and started to shake her and yell in her face. She then started to cry saying she wanted to go somewhere else where people were nice to her.

R85's Allina Senior Care Transitions Acute Care Visit dated 05/09/18, indicated R85 was seen by nurse practioner (NP)-A due to increased behaviors/delusions (a persistent false psychotic belief). The note indicated she had 1.5 to 2 weeks of challenging mental health symptoms and was seen on 5/9/18, regarding acute escalation, she had delusions of being tied down and that her family is stealing from her and police need to be called and the prior week she had self injurious behaviors of throwing herself on the floor and had been attempting to treat her psychosis without moving her from familiar surroundings. This afternoon she began yelling call the police and the behaviors could not be re-directed, could not be left alone, she was not consoled by family and also said she would commit suicide with a scissors. The report indicated FM-A was in agreement with geri-psych emergency evaluation.

R85's Allina Medical Transportation Prehospital Care Report dated 5/9/18, at 5:24 p.m. indicated she was seen for mental health evaluation due to having some sudden behavior changes. The report indicated she was screaming out to call the police and that her daughter was kidnapped, grabbed at aides shirt, and shook her and yelled. The report indicated she was crying and expressing she wants to go somewhere else where people are nice.

A Psychiatric Consultation dated 5/10/18, indicated she was seen in her room at the

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emergency department and was having breakfast with her 1:1 sitter. R85 stated, "They always seem they are picking the other story." The report indicated she wanted to go home and after her accident everything changed forever and she hates the nursing home. When asked about suicidal plans or ideation she responded, never. The report recommendation was to continue to pursue inpatient psychiatric hospitalization for further evaluation, medication management and stabilization.

A Nursing Home Incident Reporting report indicated on 5/10/18, at 11:10 a.m. a report was submitted to the State agency (SA). The report indicated the incident occurred 5/9/18, at 14:44 p.m. and R85 expressed a wish to harm self, displaying negative behaviors in room. Nursing assistant (NA)-F who was in room with two coworkers stated that coworker (NA)-G made unkind statements to the resident. NA-G was suspended pending investigation. The report further indicated R85 was transferred to higher level of care to meet mental health needs. An Investigation Report Summary dated 5/14/18, at 14:26 indicated NA- F stated she entered the room when NA-G and NA-H were providing cares for R85. The facility utilizes electronic device for charting. NA-F stated NA-G said to the resident she was going to record the resident's behavior on the electronic device so she could show it to the resident at a later time. NA-F said this was inappropriate and in-congruent with the training the facility offers regarding resident care and reported this to her supervisor. When interviewed NA-G stated she did say that but was joking. NA-H confirmed NA-G mentioned recording the resident but felt the resident did not appear to be offended. In addition, the report

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indicated the facility social worker interviewed eight residents that NA-G provided care for and no other resident had concerns regarding the care that she provided. The facility believes this was an isolated event.

Review of Progress Notes from 2/13/18 to 5/09/18, did not identify any suicidal ideation or claims of staff being mean to R85.

During interview 5/23/18, at 9:39 a.m. registered nurse (RN)- E stated NA-F reported the incident with NA-G's commenting of recording R85 on 5/10/18, sometime in the morning. RN-E stated she thinks NA-F reported it the next day because she was in shock. RN-E stated NA-F said she couldn't sleep that night and realized she needed to report the incident. RN-E stated NA-G never recorded anything because she thought you can't on the phones. RN- E further stated when the resident was asking for the scissors and commented about committing suicide that was right after NA-G made the comment of recording her and playing it back. RN-E stated R85 had never made comments of suicide prior to the incident. RN-E stated R85 does have behaviors of yelling out and throwing herself on the floor but her behaviors were never as bad as they were on 5/9/18. RN-E stated R85 was sent to hospital for geri-psych evaluation and had not returned yet.

During interview 5/23/18, at 10:09 a.m. NA-F stated that on 5/9/18, after lunch around 1-1:30 p.m. she entered R85's room and NA-G and NA-H were providing cares while R85 was yelling out. NA-G took out her phone she used for charting and stated, "I am gonna video tape you and later you can watch it to see how you acted like." NA-F then stated she thought to herself

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"Are you kidding me I helped them do the rest and just walked out of the room I didn't say anything I was in shock." NA-F stated R85 never joked or laughed in her room during the incident, her behaviors became worse after the incident with yelling and screaming. NA-F stated she should had reported the incident immediately and had been trained to that but she was in shock and had not.

During interview 5/23/18, at 12:50 p.m. administrator stated the aides got the i-phones for charting on 2/13/18, and before they received the i-phones information technology (IT) disabled the recording and taping feature on all of these phones.

During interview 5/23/18, at 12:51 p.m. NA-F stated prior to the incident on 5/9/18, R85 had not made any comments of staff being mean to her.

During interview 5/23/18, at 2:16 p.m. director of nursing (DON) stated after the incident they did training on each unit with all staff on abuse and reporting. The DON stated they took the incident very seriously and was going to terminate NA-G and she chose to resign instead.

During interview 5/23/18, at 3:21 p.m. NA-I stated he worked the p.m. shift and is full-time. NA-I stated R85 does have behaviors of yelling which occurred daily. NA-I stated he had never heard R85 make comments of suicide or that staff are mean.

Although the Associated Clinic of Psychology report identified R85 had behaviors and adjustment difficulty they recommended R85 would benefit from staff support of, kindness,

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patience and reminders that she is well liked, and staff to take turns working with her and support each other and her distress. After the incident on 5/9/18, R85's behaviors escalated and she wanted to go somewhere were people are nice, made suicide comments which required her to be admitted for inpatient psychiatric hospitalization.

The facility Social Media Policy dated 1/10/18, indicated residents will be protected from invasion of privacy and/or abuse that might occur from photographs, videotapes, digital images, and recordings during resident care or other facility activities. The policy stated staff may not take or release images or recordings of any resident without written consent. Written consent must be obtained from the resident or representative prior to obtaining images or recordings of the resident for any purposes other than investigation of abuse, neglect or emergencies, and photography obtained for personal/family use at verbal request of resident or family.

The facility Abuse Prevention Program revised January 2018, indicated residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the residents symptoms.

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		7/6/18

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

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F 609	Continued From page 25 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State Agency (SA) was notified timely of potential abuse/and or mental anguish for 1 of 1 residents (R85) who was threatened by staff to be video taped and replayed to her. In addition, the facility failed to timely report an incident of potential resident mistreatment or abuse before commencing an investigation for 2 of 2 residents (R8 and 59) when staff unilaterally initiated grooming of their perineum areas.	F 609	Facility management staff have been retrained on the need to report all potential vulnerable adult situations to the Administrator and Director of Nursing immediately (6/13/18). The Administrator and the Director of Nursing are aware of the need to timely report to OHFC per regulation. All staff members will be retrained on resident rights, vulnerable adult and elder justice act. Facility will train additional	

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Findings include:

R85's admission Minimum Data Set (MDS) dated 3/26/18, indicated she was moderately cognitively impaired, displayed no behaviors and needed extensive assist from staff for activities of daily living (ADL)'s. R85's Admission Record undated indicated she had adjustment disorder, injured in unspecified motor vehicle accident with multiple fractures. R85's care area assessment (CAA) dated 2/22/18, indicated mood and behavior did not trigger.

R85's care plan dated 4/9/18, indicated she admitted to the short term rehab area in the facility secondary to motor vehicle accident (MVA) and was previously living at home. The care plan further indicated R85 was at risk for abuse by others related to potential inability to remove self from harm and limited mobility related to MVA with multiple injuries. The care plan directed staff to follow facility guide lines for reporting injury or harm to the resident. In addition the care plan indicated R85 had a behavior problem of yelling out/screaming inappropriately in resident areas and room, putting herself on the floor from bed and profusely yelling at staff. Staff were directed to provide opportunity for positive interaction, attention and stop and talk in passing as able.

R85's Associated Clinic of Psychology report dated 2/14/18, indicated she was seen for evaluation of her mood. The report indicated she had mild irritability, agitation and anger and had no suicidal nor homicidal ideation. The report recommended her to benefit from staff support, kindness, patients and reminders that she is well liked. R85 was seen again on 4/11/18, for adjustment disorder with depressed mood. The

Provider's Plan of Correction (F 609, continued):

staff members on how to report suspected vulnerable adult incidents to OHFC to ensure timeliness.

Vulnerable Adult Policy was reviewed and is current and up to date.

Each vulnerable adult report will be logged for date and time initial concern received, date and time administrator notified, date and time reported to OHFC. This log will be analyzed every time a VA is filed to ensure compliance with reporting standards.

All vulnerable adult incidents/reports and the results of the logging audits will be reviewed every two months at the QAA meeting.

Administrator, Director of Nursing, and Director of Social Services will be responsible.

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report indicated she would benefit from staff kindness, patience, support and reminders she is a valuable member of the community. Lastly R85 was seen on 4/30/18, which indicated she had behaviors of screaming and crying out, sometimes at night and throwing herself out of bed. The report recommended staff kindness and support, staff take turns working with her and support each other and her distress is related primarily to pain, frustration with slowness of her healing. The report indicated she was on trial of Celexa (antidepressant) and was being discontinued due to lack of symptom improvement and daughter reluctant to have her start on medications that may have side effects that would exacerbate difficulties with her bowels. The report indicated she had no suicidal or homicidal ideations.

A Nursing Home Incident Reporting report indicated on 5/10/18, at 11:10 a.m. a report was submitted to the State Agency (SA). The report indicated the incident occurred 5/9/18, at 14:44 p.m. and R85 expressed a wish to harm self, displaying negative behaviors in room. Nursing assistant (NA) who was in room with two coworkers stated that coworker made unkind statements to the resident. The NA was suspended pending investigation. The report further indicated R85 was transferred to higher level of care to meet mental health needs. An Investigation Report Summary dated 5/14/18, at 2:26 p.m. indicated Nursing Assistant NA- F stated she entered the room when NA-G and NA-H were providing cares for R85. The facility utilizes electronic device for charting. NA-F stated NA-G said to the resident she was going to record the resident's behavior on the electronic device so she could show it to the resident at a

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later time. NA-F said this was inappropriate and in-congruent with the training the facility offers regarding resident care and reported this to her supervisor. When interviewed NA-G stated she did say that but was joking. NA-H confirmed NA-G mentioned recording the resident but felt the resident did not appear to be offended. In addition the report indicated the facility social worker interviewed eight residents that NA-G provides care for and no other residents had concerns regarding the care that she provided. The facility believes this was an isolated event.

Review of facility Progress Notes on 5/09/18, at 2:43 p.m. indicated R85 was heard yelling out from down the hall. Residents nurse reported R85 had been yelling out for approximately 20 minutes and was not able to be calmed down or redirected with 1:1 discussion. R85's daughter was called by staff to see if talking to daughter would calm her down, however she continued to scream. R85 had asked maintenance staff member for a scissors during this time of yelling out with no reasoning. Writer approached resident and asked to visit, resident immediately escalated stating , "Are you on their side? I'm going to walk out of here, I'm just going to have to commit suicide." Resident then continued to scream not letting writer get any words in for comfort. At that time a therapist approached to talk with resident and writer went to medical doctor (MD) and social worker (SW) to discuss a plan. Writer communicated residents comment of suicide. Per Unity Hospital Psychiatric Unit, we were advised to send to Unity emergency room (ER) for admit to the psychiatric unit due to escalating behaviors and risk for self harm.

Progress Note 5/9/18, at 3:04 p.m. indicated R85

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F 609	Continued From page 29 was yelling to call the police and that they kidnapped her daughter, she had just finished talking to her on the phone. During the morning when aide was helping patient get up, resident grabbed the aids shirt and started to shake her and yell in her face. She then started to cry saying she wanted to go somewhere else where people were nice to her. During interview 5/23/18, at 9:39 a.m. registered nurse (RN)- E stated NA-F reported the incident with NA-G's commenting of recording R85 on 5/10/18 sometime in the morning. RN-E stated she thinks NA-F reported it the next day because she was in shock. RN-E stated NA-F said she couldn't sleep that night and realized she needed to report the incident. RN-E stated NA-G never recorded anything because she thought you couldn't on the phones. RN- E further stated when the resident was asking for the scissors and commented about committing suicide that was right after NA-G made the comment of recording her and playing it back. RN-E stated R85 had never made comments of suicide prior to the incident. RN-E stated R85 had behaviors of yelling out and throwing herself on the floor but her behaviors were never as bad as they were on 5/9/18. RN-E stated R85 was sent to hospital for geri-psych evaluation and had not returned yet. During interview 5/23/18, at 10:09 a.m. NA-F stated that on 5/9/18, after lunch around 1-1:30 p.m. she entered R85's room and NA-G and NA-H were providing cares while R85 was yelling out. NA-G took out her phone she used for charting and stated "I am gonna video tape you and later you can watch it to see how you acted like." NA-F then stated she thought to herself "Are you kidding me". I helped them do the rest	F 609		

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and just walked out of the room I didn't say anything I was in shock. NA-F stated R85 never joked or laughed in her room during the incident, her behaviors became worse after the incident with yelling and screaming. NA-F stated she should had reported the incident immediately and had been trained to that but she was in shock.

During interview 5/23/18, at 9:39 a.m. registered nurse (RN)- E stated NA-F reported the incident when NA-G made comment of recording R85 on 5/10/18, sometime in the morning. RN-E stated she thought NA-F reported it the next day because she was in shock. RN-E stated NA-F said she couldn't sleep that night and realized she needed to report the incident. RN-E stated NA-G never recorded anything because she thought you couldn't on the phones. RN- E further stated when the resident was asking for the scissors and commented about committing suicide that was right after NA-G made the comment of recording her and playing it back. RN-E stated R85 had never made comments of suicide prior to the incident. RN-E stated R85 did have behaviors of yelling out and throwing herself on the floor but her behaviors were never as bad as they were on 5/9/18. RN-E stated R85 was sent to hospital for geri-psych evaluation and had not returned yet.

During interview 5/23/18, at 10:09 a.m. NA-F stated that on 5/9/18, after lunch around 1-1:30 p.m., she entered R85's room and NA-G and NA-H were providing cares while R85 was yelling out. NA-G took out the phone she used for charting and stated "I am gonna video tape you and later you can watch it to see how you acted like." NA-F then stated she thought to herself, "Are you kidding me." NA-F stated she helped

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them do the rest and just walked out of the room but did not say anything because she was in shock. NA-F stated R85 never joked or laughed in her room during the incident and her behaviors became worse after the incident with yelling and screaming. NA-F stated she should had reported the incident immediately and had been trained to that but she was in shock.

During interview 5/23/18, at 12:50 p.m. administrator stated the NA's got the phones for charting on 2/13/18, and before they received the phones information technology (IT) disabled the recording and taping feature from the phones.

During a subsequent interview 5/23/18, at 12:51 p.m. NA-F stated prior to the incident on 5/9/18, R85 had not made comments of staff being mean to her.

During interview 5/23/18, at 2:16 p.m. director of nursing (DON) stated after the incident they did training on each unit with all staff on abuse and reporting. The DON stated they took the incident very seriously and were going to terminate NA-G but she chose to resign instead.

During interview 5/23/18, at 3:21 p.m. NA-I stated he worked the p.m. shift and was full-time. NA-I stated R85 had behaviors of yelling which occurred daily. NA-I stated he had never heard R85 make comments of suicide or statements that staff were mean.

R85's Allina Senior Care Transitions Acute Care Visit dated 05/09/18, indicated R85 was seen by nurse practioner (NP)-A due to increased behaviors/delusions (a persistent false psychotic belief). The note indicated she had 1.5 to 2

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weeks of challenging mental health symptoms and was seen on 5/9/18, regarding acute escalation, she had delusions of being tied down and that her family was stealing from her and police needed to be called. The prior week she had self injurious behaviors of throwing herself on the floor and NP-A had been attempting to treat her psychosis without moving her from familiar surroundings. This afternoon she began yelling to call the police and the behaviors could not be re-directed, could not be left alone, she was not consoled by family and also said she would commit suicide with a scissors. The report indicated daughter in agreement with geri-psych emergency evaluation.

R85's Allina Medical Transportation Prehospital Care Report dated 5/9/18, at 5:24 p.m. indicated she was seen for mental health evaluation due to having some sudden behavior changes. The report indicated she was screaming out to call the police and that her daughter was kidnapped, grabbed at aides shirt, and shook her and yelled. The report indicated R85 was crying and expressing she wanted to go somewhere else where people are nice.

A Psychiatric Consultation dated 5/10/18, indicated R85 was seen in her room at the emergency department and was having breakfast with her 1:1 sitter. R85 stated "they always seem they are picking the other story." The report indicated she wanted to go home and after her accident everything changed forever and she hated the nursing home. When asked about suicidal plans or ideations she responded never. The report recommendation was to continue to pursue inpatient psychiatric hospitalization for further evaluation, medication management and

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stabilization.

Although the facility staff were aware of R85's incident on 5/9/18, the facility failed to report the incident to the SA until the following day on 5/10/18.

R8's diagnoses, as identified on the resident Admission Record face sheet, printed 5/24/18, included Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 2/6/18 indicated R8 had severely impaired cognition.

R59's quarterly MDS, dated 4/3/18, indicated moderate, cognitive impairment.

Facility-reported incidents to the State Agency (SA) from May 2017 to May 2018, were reviewed. On 5/7/18, the assistant director of nursing made a report to the SA alleging the facility failed to treat R8 and R59 with dignity and respect when a nursing assistant trimmed hair in the pubic area. An investigative summary report in response to this incident was submitted to the SA and dated 5/8/18, which indicated the following:

On April 20, 2018, registered nurse (RN)-D received report that a resident, R8, was found to have had pubic hair removed. Initial investigation began, concern originally that staff member had inadvertently applied Nair (a hair removal product) that was in medication area being stored for R8's roommate. RN-D reported concern to the director of Nursing who instructed to examine integrity of skin- begin investigation. The report indicated RN-D and licensed practical nurse

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(LPN)-C examined R8's skin, and indicated no breaks in skin integrity were noted and no signs of trauma, including bruising or redness were noted.

The report indicated the investigation continued when RN-D spoke with nurse on duty the previous evening and night shift, and learned no nurse had applied Nair to R8. RN-D then spoke with nursing assistant (NA)-G, who worked with R8 the preceding evening who stated she shaved R8's pubic area, secondary to reports of pain and tugging on pubic hair during cleansing following fecal incontinence episodes. The report indicated NA-G asked R8 is she would allow her to do shaving and R8 responded affirmatively. The report indicated RN-D provided NA-G with verbal counseling (no date or time indicated) and instructed NA-G not to shave perineum of residents, as this was out of the scope of nursing assistant practice to determine if this should be done and also that R8 was unable to give consent.

The report indicated on April 30th nursing assistant staff noted a second resident had been shaved in the perineal area, that the shaving had occurred prior to the start of the day shift, as remnants of pubic hair were still on bedding. NA-E notified LPN-C, who with an un-named NA spoke with NA-G, who worked with R59 the preceding night. NA-G reported she shaved R59, who had asked for her legs to be shaved earlier in the week during a shower. NA-G was unable to complete the task then, but did offer to shave R59 on the night shift of April 29th into April 30th. R59 wished to be shaved then and agreed to having her perineum shaved secondary to incontinence episode and hygiene needs.

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The report then indicated on 5/3/18, the facility received contact from family member (FM)-A's attorney, who left a voicemail for the director of Social Services, who forwarded a message to the facility administrator and Director of Nursing (DON), which indicated a letter to the facility would be forthcoming.

Further, the report indicated on May 7, 2018, a letter was received from FM-A's attorney which included R8's family concerns of possible "sexual assault of (R8) as well as other inappropriate conduct." Following receipt of this letter, the facility made its initial report of potential abuse to the State Agency.

When interviewed on 5/21/18, at 10:18 a.m., nursing assistant (NA)-E stated all on the nursing staff were trained to identify abuse, and further stated that if she saw, heard or learned of anything not normal "I would report that, immediately."

When interviewed on 5/21/18, at 10:26 a.m. NA-C stated she was informed about what happened with R8 and R59 after meeting with the nurse unit manager. NA-C stated when the aide shaved R8, it was totally inappropriate, and was taking advantage of a vulnerable person who "was not able to speak for themselves." NA-C stated when she learned what happened with R8 and R59, her first reaction was it could be considered "abuse," was definitely reportable, and should have been investigated.

When interviewed on 5/22/18, at 1:46 p.m. registered nurse (RN)-D stated when she first learned of the incident involving R8, her initial

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response was the Nair (hair removal product) was used, and that R8 could potentially be injured, and not at all that R8 had her perineum intentionally shaven. RN-D stated she was new in her position as unit manager, and the situation involving R8 and later R59 was unusual and that she really did not know exactly how to handle it. RN-D stated she first reached out to the director of reimbursement, who suggested to talk to the DON. RN-D stated she told the DON everything she knew that morning. RN-D stated she then spoke with the aide who did the shaving at the beginning of her shift , either 2:30 p.m. or 4:30 p.m., and then the DON followed up with her later that evening. RN-D also stated stated she did not even consider the situation as potential abuse or maltreatment, the thought did not cross her mind, even given the location on the resident's body and the unique situation.

When interviewed on 5/23/18, at 3:31 p.m., the DON stated the facility did not immediately notify the state agency when the facility first learned of incident involving R8 and later R59 because "there was no abuse suspected." When asked how the facility determined there was no abuse or mistreatment, the DON stated they asked questions, interviewed staff, and began to investigate The DON stated as soon as they received the letter from the attorney, and there was an allegation that R8 was potentially abused, "we filed a report immediately" and then launched a full investigation.

When interviewed on 5/24/18, at 3:31 p.m., the administrator stated the incidents involving R8 and R59 and the shaving were unusual, but maintained they were not reportable because they did not meet criteria of abuse. The

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administrator stated it was "poor choice and poor judgement" on the aides' part, but stated after the investigation, "thought the aide felt she was doing something good" for the residents. The administrator acknowledged the incidents were reported and investigated after the family made a formal allegation of potential abuse.

Although the facility became aware of the first shaving incident involving R8 on 4/20/18, and the second incident involving R59 on 4/30/18, the facility failed to recognize either situation as potential violations involving mistreatment or abuse of R8 or R59. However, the report summary indicated the facility began to preliminarily investigate the incident on 4/20/18, yet only first reported to the SA then began a full investigation only after FM-A's attorney sent the facility a letter alleging potential abuse, which was or more than two weeks after learning of the first incident involving R8, and and approximately one week after learning of the incident involving R59.

A facility policy, Abuse Prevention Program, revised 1/2018, indicated residents have the right to be free from abuse and facility administration will develop and implement policies and procedures to aide the facility in preventing abuse, neglect, or mistreatment of our residents. The policy included in its definition of abuse to include verbal, mental and sexual abuse and mistreatment. The policy directed to identify and assess all possible incidents of abuse; to investigate and report any allegations of abuse within the timeframes as required by federal requirements; and to protect residents during abuse investigations. Under the Reporting section, the policy directed anyone who suspects alleged abuse or neglect of a resident should

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F 609	Continued From page 38 immediately report the situation to a supervisor. Additionally, all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported to the State Agency, and also that alleged abuse, neglect, exploitation or mistreatment will be reported within two hours, or if events that cause the allegations do not involve abuse or not resulted in serious bodily injury, the report must be made within twenty-four hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to prevent potential mistreatment from occurring for 2 of 2 residents (R8 and R59) when a staff member unilaterally initiated grooming of their perineum areas, yet continued to work on the unit until family initiated concerns	F 610	Identified staff member is not longer employed by GACC. Nurse Management staff have been reeducated (6/13/18) on the need to suspend staff member immediately pending vulnerable adult investigation should suspected	7/6/18

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there may be potential mistreatment or abuse.

Findings include:

R8's diagnoses, as identified on the resident Admission Record face sheet, printed 5/24/18, included Alzheimer's dementia. A significant change Minimum Data Set (MDS) dated 2/6/18 indicated R8 had severely impaired cognition.

R59's quarterly MDS, dated 4/3/18, indicated moderate, cognitive impairment.

Facility-reported incidents to the State Agency (SA) from May 2017 to May 2018, were reviewed. On 5/7/18, the assistant director of nursing made a report to the SA alleging the facility failed to treat R8 and R59 with dignity and respect when a nursing assistant trimmed hair in the pubic area. An investigative summary report in response to this incident was submitted to the SA and dated 5/8/18, which indicated the following:

On April 20, 2018, registered nurse (RN)-D received report that a resident, R8, was found to have had pubic hair removed. Initial investigation began, concern originally that staff member had inadvertently applied Nair (a hair removal product) that was in medication area being stored for R8's roommate. RN-D reported concern tot eh director of Nursing who instructed to examine integrity of skin- begin investigation. The report indicated RN-D and licensed practical nurse (LPN)-C examined R8's skin, and indicated so breaks in skin integrity were noted and no signs of trauma, including bruising or redness were noted.

F 610

perpetrator be staff member.

Each vulnerable adult report will be logged for date and time initial concern received, date and time administrator notified, alleged perpetrator suspension date and time, and date and time reported to OHFC. This log will be analyzed every time a VA is filed to ensure compliance with reporting standards.

All vulnerable adult incidents/reports and the results of the logging audits will be reviewed every two months at the QAA meeting.

Policy and Procedure for Vulnerable Adults was reviewed, no changes were made.

Administrator, Director of Nursing, and Director of Social Services will be responsible.

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The report indicated the investigation continued when RN-D spoke with nurse on duty on previous evening and night shift, and learned no nurse had applied Nair to R8. RN-D then spoke with nursing assistant (NA)-G, who worked with R8 the preceding evening, and stated she shaved R8's pubic area, secondary to reports of pain and tugging on pubic hair during cleansing following fecal incontinence episodes. The report indicated NA-G asked R8 is she would allow her to do shaving and R8 responded affirmatively. The report indicated RN-D provided NA-G with verbal counseling (no date or time indicated) and instructed NA-G not to shave perineum of residents, as this was out of the scope of nursing assistant practice to determine if this should be done and also that R8 was unable to give consent.

The report indicated on April 30th, nursing assistant staff noted a second resident had been shaved in the perineal area, that the shaving had occurred prior to the start of the day shift, as remnants of pubic hair were still on bedding. NA-E notified LPN-C, who with an un-named NA spoke with NA-G who worked with R59 the preceding night. NA-G reported she had shaved R59, who had asked for her legs to be shaved earlier in the week during a shower. NA-G was unable to complete the task then, but did offer to shave R59 on the night shift of April 29th into April 30th. R59 wished to be shaved then and agreed to having her perineum shaved secondary to incontinence episode and hygiene needs.

The report then indicated on 5/3/18, the facility received contact from family member (FM)-A's attorney, who left a voicemail for the director of Social Services, who forwarded a message to the

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facility administrator and Director of Nursing (DON), which indicated a letter to the facility would be forthcoming.

Further, the report indicated on May 7, 2018, a letter was received from FM-A's attorney which included R8's family concerns of possible "sexual assault of (R8) as well as other inappropriate conduct." Following receipt of this letter, the facility made its initial report of potential abuse to the SA.

When interviewed on 5/21/18 at 10:26 a.m. NA-C stated she was informed about what happened with R8 after meeting with the nurse unit manager. NA-C stated when the aide shaved R8, it was "totally inappropriate," and she thought the aide should have gotten fired the first time. NA-C stated the aide "got talked to" and was confronted on it. NA-C stated the aide still worked, and then the aide did it a second time and shaved R59. NA-C stated the aide who shaved R8 and R59 thought they "were too hard to clean up, but I don't know, there could be more to it, and it's messed up." NA-C stated she worked with R8, about 2 weeks after the incident, when [R8's] family member FM-B found out. NA-C stated FM-B found out "from somebody" who worked on the floor,and stated I guess R8's family was never told about what happened. NA-C stated FM-B then told FM-A what happened, and "FM-A reported it to the state." NA-C stated FM-B started crying in front of me, and said "her mom was being abused here" and "she thought this was a good place" and "the person who did this is still working." NA-C stated FM-B felt "upset, embarrassed" and stated "this was a very sad situation." NA-C stated when she learned what happened with R8 and R59, her first reaction was

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someone taking advantage of a vulnerable person who "was not able to speak for themselves."

When interviewed on 5/21/18, at 6:34 p.m. family member (FM)-B stated she learned about what happened to her mother from one of the NA's who worked the floor. FM-B stated she also learned there was a second resident who had been shaved. FM-B recalled having a conversation with the aide, identified as having shaved R8's perineum, sometime after she learned her mother was shaven, but before she knew about it.. FM-B stated the worker was my mom's aide that night, and the aide told me "I'll take good care of your mother." FM-B stated after having leaned what happened and when the shaving occurred, "I wondered why" they would let that aide take care of my mother again." FM-B stated it upset her that the facility knew who did the shaving, and "they still allowed that aide to continue work with my mother."

When interviewed on 5/22/18, at 1:46 p.m. registered nurse (RN)-D stated when she first learned of the incident involving R8, her initial response was the Nair (hair removal product) was used, and that R8 could potentially be injured, and not that R8 had her perineum intentionally shaven. RN-D stated she was new in her position as unit manager, and the situation involving R8 and later R59 was unusual and she really did not know exactly how to handle it. RN-D stated she first reached out to the director of reimbursement, who suggested to talk to the DON. RN-D stated she told the DON everything she knew that morning. RN-D stated she then spoke with the aide who did the shaving at the begin of her shift , either 2:30 p.m. or 4:30 p.m.,

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and the DON followed up with her later that evening. RN-D also stated stated she did not even consider the situation as potential abuse or maltreatment, that thought did not cross her mind, even given the location on the resident's body and the unique situation. RN-D acknowledged the aide, NA-P, who did the shaving, continued to work on the unit. RN-D stated NA-P got a warning on April 20th, regarding R8, and after shaving R59, got a written final notice in May, but was unsure of the date, but NA-P continued to work, and then she was let go.

When interviewed on 5/23/18, at 3:31 p.m., the DON stated the facility did not immediately notify the SA when the facility first learned of incident involving R8 and later R59 because "there was no abuse suspected." When asked how the facility determined there was no abuse or mistreatment, the DON stated they asked questions, interviewed staff, and began to investigate The DON stated as soon as they received the letter from the attorney, and there was an allegation that R8 was potentially abused, "we filed a report immediately" and then launched a full investigation. The DON stated at the time of the incident, they did not believe the incident to be an allegation of potential mistreatment, but rather "poor judgment" of a nursing assistant, and not reportable. The DON stated when the family made the allegation, although not sure of the exact dates, but was "in early May," the nursing assistant who did the shaving was suspended, and shortly after that, the aide's employment was involuntarily terminated.

NA-P's personnel file was reviewed. A document, Record of Disciplinary Action, dated 5/3/18

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indicated NA-P received oral warning on 4/20/18, and a written final warning on 5/3/18 referencing the shaved pubic hair of R8 and subsequently R59. A second Record of Disciplinary Action, dated 5/8/18, indicated NA-P's employment was terminated.

Although the facility became aware of the first shaving incident involving R8 on 4/20/18, and the second incident involving R59 on 4/30/18, the facility failed to recognize either situation as any potential violation involving abuse or mistreatment of R8 or R59. However, the report summary indicated the facility began to investigate the initial incident on 4/20/18, yet only first reported to the SA after FM-A's attorney sent the facility a letter alleging potential abuse, which was or more than two weeks after learning of the first incident involving R8, and and approximately one week after learning of the incident involving R59. Additionally, NA-C continued to work as a nursing assistant between April 20th when the first incident occurred until the termination of employment, potentially leaving R8, R59 and other residents at risk for mistreatment or abuse.

A facility policy, Abuse Prevention Program, revised 1/2018, indicated residents have the right to be free from abuse and facility administration will develop and implement policies and procedures to aide the facility in preventing abuse, neglect, or mistreatment of our residents. The policy defined abuse to include, among others, verbal, mental and sexual abuse and mistreatment. The policy directed to identify and assess all possible incidents of abuse; to investigate and report any allegations of abuse within the timeframes as required by federal requirements; and to protect residents during

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F 610	Continued From page 45 abuse investigations.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or	F 622		7/3/18

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discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including

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F 622	Continued From page 47 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility's pursuit to discharge lacked justification for 1 of 1 residents (R45) reviewed for admission, transfer and discharge. Findings include: R45's diagnoses, as identified on the Diagnoses Report printed 5/24/18, included dementia with behavioral disturbance, Parkinson's disease, and anemia. R45's significant change Minimum Data Set (MDS) dated 3/18/18, indicated severe cognitive impairment. The MDS, in section E, the presence and frequency of wandering, Has the resident wandered?, indicated "behavior not exhibited." During observation on 5/22/18, at 9:30 a.m., R45 was seated in his wheel chair in the activity room on the 100's unit, he requested staff to push him to his room. At 9:36 a.m. nursing assistant (NA)-K and NA-L assisted R45 to transfer from his wheel chair into the bathroom using a mechanical lift. During the transfer on and off the toilet, NA-K told R45 what was going to happen; R45 exhibited no sign of distress or discomfort and otherwise had little response.	F 622	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility¦ s allegation of compliance. Discharge notice rescinded for R45. There are no other residents being considered for facility initiated discharge at this time. GACC issues discharge notices rarely. Every attempt is made to provide necessary services within the facility without disruption in service. In the event the facility is struggling to manage caring for a resident, the case will be reviewed with the Minnesota Ombudsman's Office and the Corporate Director of Quality	

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F 622	Continued From page 48 During a subsequent observation on 5/24/18 at 9:05 a.m. R45 was wheeled off the unit and into a large room where painting supplies were set up, and R45 stated "I am going to make another picture!" As R45 approached, the art therapist (AT) asked R45 "what is new with you" and if he was ready fro Memorial day. The AT began working one-to-one with R45, and began painting a landscape picture. The AT suggested what to paint and solicited input from R45 as to what color leaves to paint on the tree and encouraged R45 to hold the brush, or sponge, intermittently using hand-over-hand assistance to guide R45. During the art therapy, R45 was engaged and observed to be smiling while he painted. A facility document, Facility-initiated discharge documentation re: (regarding) [R45], dated 3/26/18 indicated "The resident's discharge from Guardian Angels Care Center was necessary for the residents welfare and his needs that cannot be met in the facility. The safety of R45 in the facility is endangered due to the behavioral status of the resident. The document indicated the specific needs the facility could not meet included: psychosocial, emotional and safety needs. R45's behaviors included yelling profanities, wandering into other's rooms, all of which put his safety at risk due to risk for bullying by other residents. R45 also had past elopement and remained at risk due to exit-seeking behaviors. The document then indicated efforts to meet those needs included: -- begin followed by a psychologist for psychotherapy, coping support, CBT (cognitive behavioral therapy) and problem solving therapy; --medication management by primary provider; --non-pharmacological interventions, which	F 622	Improvement, Education and Risk Management to verify discharge notice is justified prior to issuance. Training done 6/15/18. Policy and Procedure reviewed and updated. Each instance of suspected need to issue discharge notified will be reviewed by the facility Administrator, Director of Nursing, Director of Social Services, Corporate Director of Quality Improvement, Education and Risk Management, and Minnesota Ombudsman's office. - 100% audit. All instances will be reviewed at every 2 month QAPI meetings. Administrator will be responsible for this.	

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included:
--private room due to behaviors;
--assisting with residents preferred activities;
--trial various living areas within unit to determine where res felt most at ease
--Staff engaged in conversation surrounding past work experience
--Resident referred and seen by facility chaplain for support
--offered suckers during loud verbalizations/behaviors; trialed as reinforcements
--Offered watercolor painting pictures of airplanes
--offered beverages of choice (enjoys hot cocoa)
--Offered French Fries from Mc Donald's
--offered warm blanket
--offered phone to call brother
--Visits from volunteers
--Activity's department offered interventions
--the use of a code alert on wheel chair (location alarm);
--facility has cameras in place; and
--staff engagement in frequent monitoring of resident's whereabouts.

The document then identified the receiving facility would meet the needs of R45 which could not be met at the current facility: The resident required discharge to a secured, locked memory unit for programs that are better designed to meet the resident's psychosocial and emotional needs and increase his quality of life. The locked unit will lessen the risk for further elopement that could result in injury or death.

When interviewed on 5/21/18 at 10:51 a.m., family member (FM)-D stated ever since R45 had

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F 622	Continued From page 50 the elopement in January, the facility had been trying to discharge him. FM-D stated he did not really understand why they want to discharge R45, and questioned if it was for liability reasons or was it just to retaliate against him because he got out, or do they not want to take care of R45. FM-D stated he "is very satisfied" with the cares and services R45 gets at the facility, and it was also very important for him to be in close proximity to his family. FM-D stated "a while back" he felt the facility was "going to dump" R45 at the hospital, when they sent him to the emergency room in hopes to get him to some kind of in-patient treatment. FM-D stated he believed they would not have taken R45 back had that happened. FM-D went on to state he felt this facility could meet R45's needs and there was no good reason to discharge him from the nursing home. FM-D stated at a recent care meeting, he spoke with primary care provider (PCP)-A, who said he did not have a say in discharging a resident, but FM-D stated PCP-A said the facility could take care of R45. FM-D stated "I'm not doctor, but I got eyes, ears and common sense" to see the facility takes care of the same kind of people, with behaviors as [R45]. FM-D stated he was very aware R45 had dementia, swears, and wandered in others' rooms, and, like other residents, had good days and not so good days. FM-D stated he was "very upset" because he sees R45 deteriorating, is on hospice and may only have six months to live, and can't understand whey they want to make R45 move again and put him through more. FM-D stated he did not like this whole "dumping" thing. FM-D stated [R45] really liked it here, and he's told me that, and the quality of life is good, and [R45] "is the happiest I've seen him" in the nursing home. FM-D stated he doesn't want to have to have him move and	F 622		

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start that all over again, since they can and do a great job of taking care of [R45] here now.

When interviewed on 5/21/18 at 4:11 p.m., the medical director (MD) stated he was aware the facility "has been trying" to move R45, thinking that this was not an appropriate placement. While stating he was not familiar with the full care needs of R45, the MD knew R45 had an elopement from the facility, but discharging him from the facility is not what the family wants. The MD stated a move to a new facility would be difficult for R45, and if he is on hospice, then "we should take care of him."

R45's progress notes from 11/1/17 through 5/24/18, were reviewed. Sample of progress notes from May 2018 included:
--5/24/18 (nursing): Resident was observed hand waving X (times) 3, and yelling X3, Resident was yelling "It's mine. Bullshit. Go ahead tell them.
--5/22/18 (spiritual care): I met with R45 twice today. Once during the last 15 minutes of breakfast and another was right before lunch. I did so on both occasion after receiving a consult request from the NUM (nurse unit manager). During both visits (R45) was sitting in the middle or the bath between the RN station and the dinette swearing about "the general" taking his "drugs and money." I successfully redirected (R45) both times and reassured him that all was well and that he'd experienced no theft of anything.
--5/22/18 (activities): Resident enjoyed looking at pictures of planes on the iPad with staff as evidenced by talking, smiling and telling stories about planes. Positive verbalizations.
--5/18/18 (nursing): Resident had distressing thoughts/yelling out X3 observed this shift.

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F 622	Continued From page 52 Resident was offered warm blanket, refused, hot chocolate, refused. Writer spoke to resident 1:1 which appeared to help redirect resident's thoughts and behavior. --5/16/18 (activities): balloon-ball toss; resident declined invite. --5/16/18 (hospice): Pt (Patient) up in wheel chair throughout assessment, Pt quiet throughout today's visit; eyes are unfocused when speaking, pt unable to track conversation per baseline. No s/sx (signs or symptoms) of pain noted. LS (lung sounds) clear. Abdomen soft, non-tender. Edema absent at this time. Collaborated with facility staff, no changes to plan of care at this time. Writer provided supportive presence. Monitor comfort, introduce new RN case manager next visit. --5/15/18 (nursing): Resident was observed hand waving and yelling X3 this shift. Resident was re-directable with verbal prompting. --5/15/18 (activities): 1:1 (one to one) res was outside with a small group, swearing loudly and upsetting other residents. Staff brought (R45) into activity room to try to calm him down. Soft music was put on and was given sensory items and a magazine as an intervention. (R45) was not interested in the objects but eventually quieted down and left the room. --5/13/18 (nursing): No target behaviors were observed or reported this shift. --5/12/18 (nursing): Resident sitting near the nurse station this am (morning) talking out loud. Disruptive to others in dining room. Able to redirect to breakfast. After breakfast wandering up and down hallway and into other' rooms. 11 a.m. sitting talking/yelling out loud, talking about checks, out loud. --5/9/18 (nursing): Yelling "that man keeps stealing my money for drugs"unable to redirect at	F 622		

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first. Able to redirect with non-pharm (non-pharmacological) interventions using music on boom box. Nurse practitioner here and updated and will continue prn (as needed) Seroquel (anti-psychotic medication) order. [family] called here and was updated on behaviors/medications and that activities has volunteers available at times when has increase in behaviors.
--5/5/18 (nursing): behaviors, yelling out about money, stealing, drugs, unable to redirect, after 3rd attempt able to redirect with some hot cocoa and music. Disruptive towards residents in dining room after lunch.
--5/4/18 (activities): 1:1, staff member offered taking a stroll as an intervention while resident was agitated. Resident put feet on the group and said "No, leave me alone" later staff member came back to offer going outside as another intervention. Resident declined offer.
--5/3/18 (activities): Bingo. Attended Bingo for a few minutes but did not participate, then strolled off, inattentive.
--5/3/18 (nursing): resident cooperated with HHA (home health attendant) during shower this a.m. Requested HHA to shave off moustache (its too hot.) Resident noted to yell out a few time in louder volume, talking about checks, money and drugs, upsetting to residents in dining room. Able to redirect resident away from dining room area.
--5/2/18 (nursing): No disruptive behaviors this shift. Resident was quiet and calm, easy to redirect. no aggressiveness noted.
--5/2/18 (activities): Staff member offered an audio tape of resident's brother talking as an intervention while he was agitated. Resident did not want to wear the headphone or listen to the tape.
--5/2/18 (nursing): Resident wandering on unit.

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Wandered into a resident's room and sat in wheel chair by resident's bed. The resident alerted staff to resident's behavior by putting on call light and asking (R45) be removed. Writer removed resident from the room and brought to common area in the sunlight. Reminded (R45) cannot be going into other's rooms. (R45) said "I know, but he's sick." Writer reassured resident that nursing staff would address his concern and take care of said resident. Currently sitting at the end of the hall in the sunlight talking out loud at an appropriate tone of voice and waving hand/arm in the air.

When interviewed on 5/21/18, at 3:23 p.m. nursing assistant (NA)-B stated R45 was "easy peazy" to work with. NA-C stated R45 had behaviors, but so did other residents, and if you watched for certain "cues" when you needed to react, you could be successful and R45's behavior were manageable. NA-C stated some strategies that worked for R45 were consistent care givers, frequent and one-to-one attention, low stimulation and quiet environments. NA-C stated we can take care of R45 and thought his best placement "was right here."

When interviewed on 5/22/18, at 9:39 a.m. NA-R stated R45 had a "code alert" band on his wheel chair "to alert us" that he may be going off the unit. NA-R stated R45 used his wheel chair to move about and she had not seen R45 trying to escape from his chair or the building. NA-R stated he has not eloped again. NA-R stated mostly you just have to "distract" R45, and added he needed more one to one attention. NA-R stated R45's activity interests seemed to focus around ones with music, and that music often worked to distract and redirect him. In my

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opinion, NA-R stated "we do great here" taking care of R45.

When interviewed on 5/24/18, at 9:07 a.m., the director of recreation (DoR) talked about R45's involvement with activities which she stated included art therapy, attending church and other programs with music (R45 may start clapping to the music), occasional going to Bingo, other one-to-one activities and interaction with volunteers. The DoR stated R45 was positioned at the periphery during larger groups so he could leave if he wanted, and that staff invite him to come, then encourage to stay and participate in as many activities. The DoR stated she thought "we meet his activity needs here." The DoR stated she had not seen R45 be physically aggressive to other residents, nor has she seen others strike out at R45. The DoR stated R45 does wave the arm, but while that may distract, it did not interfere with activities.

When interviewed on 5/24/18 at 10:34 a.m., registered nurse (RN)-D stated it takes a lot of collaboration, the whole interdisciplinary team, to meet R45's needs, when asked if R45's needs were being met at the facility. RN-D stated her concern was R45 "needed structured activities" around the clock, and have heard other facilities could better meet that need. RN-D stated R45 had the potential to be bullied, although she had not seen that, and stated R45's wandering into others' rooms increased that potential. RN-D also stated hospice was on board, "but they are not here 24/7." RN-D stated family had indicated their desire to keep R45 in the facility and didn't care "what condition R45 was in." RN-D said that concerned her, and stated that while we have to be aware of the family's desires, "I need to

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consider what is best for the resident."

When interviewed on 5/24/18 at 11:38 a.m., licensed social worker (LSW)-A stated the facility had initiated an involuntary discharge for R45. LSW-A stated the biggest reason was "we feel we cannot meet" R45's needs, citing his wandering and elopement potential. LSW-A stated if R45 got past the first set of alarms on the 100's unit going toward the front door, it could be dangerous, especially on the weekends, when there are not as many staff on duty. LSW-A stated R45 had not tried to go outside on his own, but added R45 had gone up and down the hallways and throughout the building, and is "very mobile."

LSW-A stated R45 was admitted in November of 2016, having come here originally for short-term rehab, and prior to that lived with his mother. LSW-A stated the discharge goal then was to return home, and if that did not go, then discharge to assisted living. LSW-A stated due to his behaviors and hallucinations, "nobody would take him." LSW-A stated R45 was moved to a double room on the 300's wing, a long -term unit, and then in February of '17 it was thought a private room would be better, as R45 was having paranoia, thinking the roommate was stealing or taking his things., and now it has been more than a years since being moved to the 100's wing, where he was now. LSW-A stated the behaviors were still present, the hallucinations, swearing, and stated those were daily and can be hourly. LSW-A stated we have tried many things, and cited an example of when the facility had construction going on, and how R45 enjoyed looking out the window, but that ended. LSW-A then listed numerous examples of

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non-pharmacological things to distract from behaviors, coloring, fast foods and other foods, we tried a motivational sticker program, taking walks, various toys, nick nacks, aroma therapy, weighted blanket, just trying to keep R45 busy. LSW-A stated things were hit and miss, and you may have success on any given day, but there was never proof anything consistently worked, except for McDonald's french fries, but even that was hit and miss.

Continuing the interview LSW-A acknowledged they had attempted to send R45 out for in-patient psychiatric treatment, and stated they had hoped there was a way to change behaviors with some medication management. LSW-A stated the in-patient program did not accept R45 because he was was too young. When asked what kind of health care setting would be a better fit for R45, LSW-A stated "a group home" would be better because of reduced stimulation, fewer clients and more one to one attention. LSW-A stated R45's limited mobility, level of required assistance, and his diagnosis really eliminated a lot of options, and added "the R45's family was not on board with that." When asked if another nursing home would be a lateral move for R45, LSW-A stated again R45 needed a secured unit which was not provided here. LSW-A acknowledged the facility currently did take care residents with similar needs of R45, including residents with dementia, behaviors, traumatic brain injury, and also residents with Parkinson's disease.

In a Genevieve progress note, dated 4/12/18, primary care provider (PCP)-A indicated R45 had been struggling with some escalating behaviors that were disruptive, that were frustrating the other residents, and once or twice were

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associated with an elopement. PCP-A indicated there had been a quite a bit of energy in trying to find a safe placement for (R45) and it was unclear that is any longer being pursued. PCP-A indicated in R45's assessment, cognitive dysfunction, showing anticipated gradual decline, and Parkinsonism. PCP-A also assessed postural instability, and indicated R45 is non-ambulatory and at this point with functional decline (R45) seems to be less of an elopement risk.

When interviewed on 5/24/18 at 2:15 p.m., primary care provider (PCP)-A stated the facility was very concerned about R45's safety, following his elopement. PCP-A stated R45 went on hospice recently and had a decline, and thought R45 would be less mobile and therefore less of a mobile threat. PCP-A also stated family wanted R45 to remain here, and wondered if they were willing to accept the risk of possible elopement. PCP-A also stated the facility's reluctance may be for the safety of the staff and concern if R45 would strike out, but added "I think they could take care of him here."

In a physician's progress note dated 4/27/18, PCP-B addressed R45's hallucinations/delusion in the assessment and plan and indicated an increase in Seroquel (anti-psychotic medication) was not noticeably effective. Now on VPA (valproic acid, a mood stabilizer medication) and other same-class meds (medications). PCP-B indicated R45's family's goal is to keep him in GACC (Guardian Angel Care Center), and was ok to continue to use meds as team sees fit. PCP-B indicated R45 will likely always have delusions and meds may lessen intensity but not alleviate completely. PCP-A indicated agreement that a

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dementia unit may be an appropriate move, but also indicated brother prefers R45 stay at GACC, avoiding transitions, likely of benefit to R45

When interviewed on 5/24/18 at 2:36 p.m., PCP-B stated the facility's reasons for wanting to discharge R45 were they felt they could not meet psychosocial needs, based on his age, and unique need for one-on-one time and attention, and R45's safety, because he had eloped. Given R45's decline, PCP-B stated she thought the pursuit of discharge would end. PCP-B stated it was difficult supporting both the facility, whose biggest concern they presented was ensuring R45's safety; and supporting R45's family, whose loved one, " is taken care of by the facility."

A facility document, Guardian Angels Care Center Facility Assessment Tool, updated 11/13/17, indicated under, "Our Resident Profile" the facility may accept residents with, or who may develop, common disease conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical management. Under Psychiatric/Mood Disorder, common diagnoses included: psychosis (hallucinations, delusions, etc.) impaired cognition, mental disorders, and Behavior that needs interventions; and under Neurological system, common diagnoses included Parkinson's disease and dementia.

Although the facility searched for alternate placement and began a facility-initiated discharge indicating it cannot meet the assessed needs of R45, the medial record, staff, providers, R45's family and medical record all indicated the facility is meeting the needs of R45. The facility assessment indicated it admits and can meet

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F 622	Continued From page 60 care requirements for residents with similar diagnoses and behavioral needs as R45. A facility document, Admission , Transfer, Discharge Rights Policy for Care Guardian Angels Care Center, last revised 11/30/17, indicated the facility accepts only residents that can be adequately cared for by the facility. Further, under section "C" transfer/discharge procedure, under the section Involuntary Transfer, the policy indicated "every effort will be made to meet the needs of the resident within the facility's scope of practice."	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		7/6/18

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resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 62	F 623		

telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to notify the ombudsman of a hospital transfer for 1 of 4 residents (R91) reviewed for facility initiated transfers.

Findings include:

Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies

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F 623	Continued From page 63 R91's admission Minimum Data Set dated 5/1/18, identified severe cognitive impairment. R91's progress note (s) identified the following: - 5/7/18, at 5:28 p.m. R91 was transferred to the hospital. - 5/8/18, at 9:47 a.m. identified R91 was admitted to the hospital. A notice of transfer was mailed to family. During interview on 5/24/18, at 1:49 p.m. the director of nursing (DON) stated the facility sent individualized notices to the ombudsman upon admission to the hospital. She stated the transfer notice was sent to the family and would ask about the notice provided to the ombudsman. Notification to the ombudsman regarding the facility initiated transfer to the hospital was requested and not provided. On 5/31/18, at 9:54 a.m. the long-term care ombudsman (O)-A provided an email. O-A identified she never received notification regarding R91's transfer to the hospital on 5/7/18. The facility's Combined Federal and State Bill of Rights dated 2/1/17, identified the facility must send a transfer notice to a representative of the Office of the State Long Term Care Ombudsman.	F 623	and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility¦ s allegation of compliance. Facility did not initiate transfer in this instance, family member initiated transfer. Notifications of all facility initiated transfers will be made to the Ombudsman's office within one week of transfer. Procedure reviewed with all Social Service staff on 6/13/18. Policy and procedure updated. An weekly audit will be conducted of 25% of hospital transfers to ensure compliance with regulation. Findings (positive and negative) will be reported at the QAA meeting every two months. Director of Social Services will be responsible for ensuring compliance.	
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		7/2/18

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F 625	Continued From page 64 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a written copy of the bed hold policy for 4 of 4 residents (R91, R89, R25 and R123) who were transferred to the hospital. Findings include: R91's admission MDS dated 5/1/18, identified severe cognitive impairment. R91's progress note dated 5/9/18, at 9:47 a.m.	F 625	Due to time limitations, no corrections can be made for R91, R89, R25, and R123. Programming changes have been made to clinical software to allow clinical report to print out providing all necessary information for hospital transfer, including transfer form and bed hold policy. Policy and procedure was reviewed and	

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identified R91 was admitted to the hospital and family member (FM)-D was offered a bed hold via telephone and chose not to hold the bed at the time.

During interview on 5/21/18, at 10:21 a.m. FM-D stated R91 was transferred to the hospital on 5/7/18. R91 was not sent to the hospital with a copy of the bed hold policy and FM-D was not given a copy of the bed hold policy. Further, FM-D was offered the bed hold verbally by telephone the following day by the social worker. FM-D declined the bed hold as he did not know what he would be agreeing to. It was required to give the bed hold policy in writing so families could make an informed decision.

During interview on 5/23/18, at 9:46 a.m. registered nurse (RN)-F stated FM-D was at the facility when R91 was transferred to the hospital and was not provided a bed hold notice and should have. The practice had been for the social worker to contact family regarding the bed hold policy.

On 5/23/18, at 3:05 p.m. licensed practical nurse (LPN)-C stated the social worker talked with families regarding the bed hold policy and the nursing staff did not send a copy of the bed hold policy with residents upon transfer to the hospital.

During interview on 5/23/18, at 3:35 p.m. the unit manager registered nurse (RN)- G stated R91 should have been sent to the hospital with a bed hold policy for family to review and it was not done.

On 5/24/18, at 10:34 a.m. licensed social worker (LSW)-B stated it was expected the bed hold be

F 625

updated. Staff will maintain a separate copy of documents sent with the resident to the hospital to verify copy of bed hold policy sent.

An audit of 100% of hospital transfers will be conducted until programming changes are confirmed in software. After programming changes are completed a 10% audit will be conducted each week.

Findings will be reported at the QAA meeting every two months.

Nurse Unit Managers will be responsible for ensuring compliance.

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given to the resident or family if on-site during a transfer. If the resident could not sign for themselves and family was not present it should be sent with the resident for family to review. She then followed up by phone call. It was important to provide a written copy so people know what they are agreeing or not agreeing to, because there is a financial component.

On 5/24/18, at 10:53 a.m. admissions coordinator (AC)-A stated the facility started putting the bed hold policy in the admission packets on 5/15/18; however it was still supposed to be given at the time of transfer.

During interview on 5/24/18, at 3:00 p.m. the administrator stated there had been issues with residents/or families being provided a copy of the bed hold policy at the time of transfers.

R25's 14 day perspective payment system (PPS) MDS dated 2/28/18, indicated severe cognitive impairment.

A review of the electronic Progress Notes identified R25 was hospitalized on 1/29/18. The narrative notes lacked documentation of notification of responsible party of the facility bed hold policy. A copy of a signed bed hold policy dated 2/3/18 for date of leave of 1/29/18 was completed by the facility.

R25's electronic Progress Notes indicated R25 was again hospitalized on 5/3/18. The documentation lacked notification of the responsible party of the bed hold policy. The Bed Hold Policy for Hospital or Therapeutic Leave Days was signed by the responsible party and facility staff on 5/17/18, 14 days after the

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F 625	Continued From page 67 hospitalization. R89's significant change MDS dated 4/30/18, indicated moderate cognitive impairment. A review of electronic Progress Notes indicated he was hospitalized on 4/19/18, however, lacked documentation the responsible party had been provided with notification in writing of the facility bed hold policy. The facility notification of bed hold policy was signed by R89's responsible party and facility staff on 4/24/18, five days after the hospitalization. On 5/24/18, at 3:21 p.m. LPN-E stated the bed hold policy used to be attached to the paperwork for hospitalizations and transfers. In the previous electronic system it would cue staff to indicate when and whom they had informed of the bed hold policy. This prompt was not reflected in the current electronic documentation system. R123 admission MDS dated 4/13/18, indicated she was cognitively intact. A facility Progress Note (PN) dated 4/20/18, at 7:54 p.m. indicated R123 had complaints of pain in her left hip and weakness. On call physician was called and received ok to send to emergency room if pain was not controlled. Patient was sent to emergency room at 7:55 p.m. per their request. A facility progress notes from social services dated 4/21/18, at 11:32 a.m. indicated received call from residents husband he was choosing not	F 625		

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F 625	Continued From page 68 to hold the bed at this time. Resident discharged to the hospital and transfer notice mailed to husband. The PN did not indicate if R123 had received the bed hold policy prior to hospitalization. During interview 5/24/18, at 10:21 a.m. the director of social services stated if a resident was sent to the hospital the nurses are supposed to send the bed hold policy and document that. If the family/resident decides to hold the bed then we call them to let them what the cost was to hold the bed and then send out the bed hold for signature. If they don't hold a bed, a transfer agreement is sent. She indicated there was no documentation the family/resident had received the bed hold policy prior to hospitalization. The Admission, Transfer, Discharge Rights Policy for Care dated 11/30/17, identified before a nursing facility transfers a resident to the hospital or goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative a written notice of the bed hold policy. If the facility determines a resident who was transferred cannot return to the facility, the facility must comply with the requirements of notices and documentation as it applies to discharges.	F 625		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the	F 626		7/6/18

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F 626	Continued From page 69 following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to re-admit a resident following a hospital discharge to the first available bed without outside intervention for 1 of 1 residents (R91) who had concerns about the facility's re-admission practices. Findings include:	F 626	R91 was readmitted to GACC. Training will be held for Admissions staff and Evening Nurse Unit Managers who provide evening and weekend coverage for admission decisions regarding readmission requirements.	

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R91's admission Minimum Data Set dated 5/1/18, identified severe cognitive impairment with verbal behaviors four to six times per week but less than daily. The behaviors had no impact on others. A diagnosis of Alzheimer's disease was identified.

R91's Progress Note dated 5/7/18, at 5:28 p.m. identified R91 was transferred to the hospital.

On 5/17/18, at 11:27 a.m. an e-mail was received from the long term care ombudsman (O)-A. O-A indicated she had to get involved in an effort to have the facility re-admit residents from the hospital. The facility had indicated they could no longer meet the residents needs. Following O-A's involvement the facility agreed to re-admit the resident.

On 5/21/18, at 10:21 a.m. family member (FM)-D stated his mother was hospitalized on 5/7/18. He did not agree to a bed hold agreement as it was not provided in written form. The hospital social worker stated the facility would not accept the resident back, as the facility did not have any available room, and could not meet her needs. FM-D did not want to move R91 to a new facility as she had been in 10 facilities since October 2017. FM-D then contacted O-A and let her know the facility was not allowing R91 to return to the facility following a hospitalization. After O-A got involved the facility allowed the resident to return to the facility on 5/15/18.

R91's hospital social service note (s) identified the following:

- 5/8/18, R91 was admitted to the hospital for altered mental status. She spoke with facility and

F 626

There was a review of all other residents that were sent to the hospital that did not hold their bed, no other readmission requests occurred.

Policy and procedure was reviewed and updated.

A weekly audit of 100% of residents who are hospitalized and request to return to the facility will be conducted to ensure readmission as required.

Findings will be reported at the QAA meeting every two months.

Admissions Coordinator will be responsible for ensuring compliance.

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a bed hold was not signed, and would need to discuss discharge plans with FM-D.

- 5/9/18, The social worker met with FM-D and he expressed wanting R91 to return to the facility. The social worker explained the facility expressed R91 would be more appropriate for long term care (LTC) and they had no LTC beds available. They discussed other placement options and a referral was sent to a new facility.

- 5/14/18, FM-D was still interested in R91 returning to the facility. The social worker spoke to the facility and they expressed there was not a bed hold signed for R91 and there were no current openings. FM-D reported he spoke to O-A regarding the resident returning to the facility, and a lack of a written bed hold policy provided. The facility stated they would re-assess for admission.

- 5/15/18, The facility would now accept R91 back. Family was in agreement and transportation was arranged for 1:00 p.m. on 5/15/18.

The facility Daily Census identified the following:

- 5/11/18, the facility had 120 beds and 6 were empty, one of which was a LTC bed with a female roommate.

- 5/12/18, the facility had 120 beds and 7 were empty, one of which was a LTC bed with a female roommate.

- 5/13/18, the facility had 120 beds and 7 were empty, one of which was a LTC bed with a female roommate.

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F 626	Continued From page 72 - 5/14/18, the facility had 120 beds and 6 were empty, one of which was a LTC bed with a female roommate. - 5/14/18, the facility had 120 beds and 3 were empty, one of which was a LTC bed with a female roommate. During interview on 5/23/18, at 9:46 a.m. registered nurse (RN)-F stated R91 had a lot of yelling behaviors before her transfer to the hospital. Upon readmission the yelling behaviors had continued. RN-F stated when R91 was in the hospital management deemed her inappropriate to re-admit to the facility. She was not aware if there were available beds within the facility. On 5/23/18, at 3:05 p.m. licensed practical nurse (LPN)-C stated she heard through "hearsay" the facility would not take her back following hospitalization due to her behaviors. During interview on 5/24/18, at 10:34 a.m. licensed social worker (LSW)-B stated she was not part of screening residents for admission or re-admission to the facility. She was aware R19 needed LTC placement; however, there were no LTC beds available. LSW-B stated the facility was obligated to re-admit R91 from the hospital if there was any room in the facility available. On 5/24/18, at 10:53 a.m. admissions coordinator (AC)-A stated when a resident/ family did not sign for a bed hold she updated the hospital social worker the resident had been discharged. If a bed hold is not signed then the hospital is required to treat it like a new admission and send a referral to the facility to screen the residents. AC-A stated R91 was screened for placement and based on	F 626		

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her "new" needs it was discussed we could not meet her needs. She had a lot more agitation, although the facility cared for multiple residents with agitation. AC-A was not aware when she was originally screened for return from the hospital, but contacted the hospital social worker and told her the facility could not meet her needs. The the hospital social worker stated FM-D had concerns regarding the bed hold and resident rights and the administrator and director of nursing (DON) followed up on whether they were going to allow her to come back. he DON and administrator made the decision for her to return.

During interview on 5/24/18, at 1:49 p.m. the DON stated the family did not sign a bed hold agreement and R91 was then discharged from the facility. A bed hold was needed to guarantee your room back. If a bed hold was not signed then the next available "appropriate" bed was given to the resident. The DON stated she screened R91 for re-admision to the facility on 5/15/18, and she was clinically appropriate to return to the facility. There was an original screening prior to the weekend, but stated there were no beds available. She stated although the census indicated there were open beds they were had been promised to new residents and the other bed on the the LTC care unit was for a male resident. Further, she had no intention not to take R91 back from the hospital, there just were no open beds. The DON could not provide evidence the beds were spoken for and there were no beds available in the facility.

On 5/24/18, at 3:00 p.m. the administrator stated if a bed hold is not signed the resident gave up their room and they were then discharged from the facility. She stated R91 was declined a room

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GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE ELK RIVER, MN 55330**

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F 626	Continued From page 74 based on the hospital stating she needed LTC and she had challenging behaviors that disrupted others. There were only transitional care unit (TCU) rooms available, when the hospital was looking to discharge R91 back to the facility. Further, the TCU was not a separate entity and all the facility beds were certified. O-A did get involved with the re-admission process. The facility agreed to accept R91 back. On 5/31/18, at 9:54 a.m. O-A provided an email. O-A identified the facility had refused to re-admit R91 to the facility when it was time to discharge from the hospital. She had many discussions with FM-A, the hospital social worker and the facility staff. She requested written discharge paperwork from the facility and none was provided. The facility did re-admit R91 after her request. The facility policy Readmission to the Facility dated 4/13, identified a resident would be readmitted to the facility to the first available bed if the facility can meet their needs, was not discharged for non payment and was not discharged because of behavior problems.	F 626		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655		7/2/18

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F 655	Continued From page 75 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include interventions for behavior management and for the use of an antipsychotic as needed (PRN) medication, on the base line care plan for 1 of 1 residents (R91) reviewed for	F 655	The care plan for R91 has been updated to include individualized approaches identified. Staff on the unit of been trained on these individualized approaches.	

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F 655	Continued From page 76 PRN psychotropic medications: Findings include: R91's admission Minimum Data Set (MDS) dated 5/1/18, identified R91 had severe cognitive impairment, with verbal behaviors four to six times weekly but less than daily. The behaviors had no impact on others. A diagnosis of Alzheimer's disease was identified. R91's Admission/Readmission Assessment and Initial Care Plan dated 5/15/18, identified R91 was re-admitted to the facility on 5/15/18, at 1:50 p.m. It included a review of medication. It did not include use of an antipsychotic (mood alternating medication) medication, target behaviors and specific interventions. R91's physician orders identified the following: - Seroquel (antipsychotic) 6.25 milligrams (mg) by mouth (po) every 6 hours PRN ordered 5/15/18, through 5/21/18, for agitation. - Seroquel 12.5 mg po every 6 hours PRN ordered 5/21/18, for 14 days for agitation. R91's May 2018 Medication Adminstration Record (MAR) identified target behaviors for use of the PRN Seroquel included yelling out, swearing, striking out at staff, that could not be redirected. The MAR did not provide interventions prior to giving the Seroquel. During interview on 5/22/18, at 1:26 p.m. nursing assistant (NA)-K stated R91 had behaviors of yelling out and repeatedly called out asking where family was. R91 was never physically aggressive,	F 655	For all residents with dementia or behavioral concerns, the Baseline Care Plan will be updated to include behavioral interventions. Family members and other appropriate individuals will be interviewed on admission to help determine individualized approaches. Policy and procedure was reviewed and updated. An audit of 10% of Baseline Care Plans will be conducted weekly for residents on antipsychotic medications and/or diagnosed with dementia. Findings will be reported at the QAA meeting every two months. Nurse Unit Managers will be responsible for ensuring compliance.	

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F 655	Continued From page 77	F 655		

but the yelling out bothered other residents on the unit. The facility had not instructed the nursing assistants on specific interventions for yelling out.

On 5/22/18, at 1:55 p.m. NA-L stated the facility had never instructed the nursing assistants on specific interventions to try when R91 was yelling out and becoming agitated.

When interviewed on 5/23/18, at 9:46 a.m. registered nurse (RN)-F stated R91's Target behaviors were listed on the MAR; however, there were no specific interventions related to the target behaviors to attempt prior to administrating PRN Seroquel. R91 yelled, and frequently swore, and was very repetitive which made her more anxious. The interventions should be directed on the care plan.

During interview on 5/23/18, at 3:05 p.m. licensed practical nurse (LPN)-C stated there were not specific interventions related to R91's PRN Seroquel use or behavior management.

On 5/24/18, at 10:28 a.m. RN-G stated the initial care plan was completed on admission by the nurse manager on duty. The initial care plan was very basic; however, the nurse could add essential items to the care plan as needed. R91's initial care plan did not have basic interventions for behavior management and antipsychotic use and should have.

During interview on 5/24/18, at 1:49 p.m. the director of nursing (DON) stated the initial care plan only covered basic resident needs until the MDS and comprehensive care plan was completed. The staff should know how to do interventions related to behaviors related to

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F 655	Continued From page 78 dementia, without instruction. The undated facility policy Care Plan- Baseline included a baseline care plan would be developed within 48 hours of admission to meet the residents immediate care needs.	F 655		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reduce the risk of elopement after removing code alert bracelet (a personal alarm activated when leaving a designated area or exit door) for 1 of 1 residents (R45) reviewed for accidents who subsequently eloped from the facility. Findings include: R45's diagnoses, as identified on the Diagnoses Report printed 5/24/18, included dementia with behavioral disturbances, Parkinson's disease, and anemia. R45's significant change Minimum Data Set (MDS) dated 3/18/18, indicated severe cognitive impairment. The MDS indicated R45 required extensive assistance for locomotion on and off the unit, and required extensive assistance with all activities of daily living (ADLs),	F 689	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. R45's Code Alert bracelet had been reapplied. An additional Code Alert monitor was installed to notify staff of R45's wandering away from unit.	7/2/18

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F 689	Continued From page 79	F 689		

including transfers. The MDS

R45's care plan, revised 2/10/18, identified R45 as an elopement risk/wanderer r/t (related to) cognitive impairment and impaired safety awareness and identified a history of random, aimless, non-goal directed wandering. The care identified goals which included R45's safety will be maintained through the review date and also R45 will not leave facility unattended through the review date. R45's care plan directed: Code alert to w/c (wheel chair) to alert staff to resident attempts of elopement and monitor whereabouts; distract from wandering by offering pleasant diversions; refer to recreation department care plan for resident specific activities; nursing staff to check for placement of code alert every shift and as needed; and staff to check functionality of code alert weekly and as needed.

During observation on 5/21/18, at 8:47 a.m., R45 was seated in his wheel chair in the activity room on the 100's wing. R45 was viewing an iPad, listening to sounds of cats and dogs, and viewing the iPad screen. Later at 10:00 a.m., R45 was seated in his wheel chair in his room when unidentified activity activity staff invited R45 to come to a painting activity in the activity room, or if R45 wanted to meet with chaplain. R45 declined both invitations, and remained seated in his wheel chair, alone in his room. At 3:39 p.m. R45 was observed in the hallway outside his room, also seated in his wheel chair, parked against the wall, and looking up at a CNA who was in the hall.. R45 was dozing off while seated in his wheel chair.

A facility document, Resident Incident Report, dated 1/13/18, indicated at 6:30 p.m. (R45)

An Elopement Assessment was developed and performed on all residents in January following this incident. This same assessment is being conducted each quarter.

Policy and Procedure was reviewed and updated.

An audit of 10% of residents will be conducted each week to determine compliance with Elopement Assessment and subsequent recommendations.

Findings will be reported at the QAA meeting every two months.

Nurse Unit Managers will responsible for ensuring compliance.

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F 689	Continued From page 80	F 689		

brought to unit by staff who reported R45 was outside at side walk, wheeling self, and wore a sweater, hat, skin on face, hands are cold.
A note dated 1/13/18, written by registered nurse (RN)-C, indicated as RN-C was walking into the break room, she saw R45 about halfway between the 100's unit and the front door of the facility, going toward the front door. When RN-C left the break room about 6:27 p.m., she saw R45 in the parking lot near the sidewalk to the 100's unit, approached R45 and asked if she could help him into the building. RN-C indicated when approaching the door, R45 asked "What is this place?" to which RN-C responded "Guardian Angels Care Center." RN-C pushed R45 into the building and informed the aides R45 was in the parking lot.

When interviewed on 5/23/18, at 2:47 p.m. registered nurse (RN)-D stated prior to when R45 was found outside of the building, we did not have a formal elopement assessment for him. RN-D stated prior to his elopement, he had a "code alert" (an alarm which sounded when a resident went past a certain area), but that the code alert had been removed on December 26th. RN-D stated around that time there was a change in the director of nursing, and there was some different perspectives, and we looked at that time at the residents who had wander guards, including R45. We asked, do the resident have a doctor's order, is there consent from the family? RN-D stated that when she reviewed R45, there was no order for the code alert, and it had not been care planned to have and use the code alert, and additionally, "we did not see him wandering or have exit-seeking behavior." RN-D stated that at a stand up meeting, we made a decision to remove the code alert. RN-D referenced a

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F 689	Continued From page 81 progress note, dated 12/26/17: "Resident's use of code alert assessed, (R45) has made no recent exit seeking behaviors. Code alert to L [left] ankle removed. Care plan updated." RN-D stated that after his elopement attempt, R45 was re-assessed, and we got an immediate order and an "ok" from his brother to place the code alert. RN-D stated since R45's incident, all residents in the facility were re-assessed for elopement, including R45, using a different assessment tool. R45's annual MDS dated 11/17/18, in section E, Presence and Frequency of Wandering, has the resident wandered?", the MDS indicated "behavior not exhibited." Prior to the removal of the code alert on 12/26/17, R45's record lacked an assessment to validate its removal. Subsequently, R45's elopement potential was reassessed. An elopement assessment dated 3/16/18, indicated R45 has wandered in the past moth, and has wandered aimlessly. The document further indicated R45 had medical diagnosis of cognitive impairment and history of wandering, and had a significant change in condition. The document summary indicated (R45) continues to have code alert (staff alerting monitor) to w/c (wheel chair) to alert staff to resident attempts of elopement and monitor whereabouts. High Risk. Care plan remains up to date. When interviewed on 05/23/18 at 10:45 a.m., the director of nursing (DON) stated prior to the the elopement attempt, R45 did have a "code alert" or wander guard in place. The DON also stated R45 did have an incident of elopement on January 13th. The DON stated prior to R45's elopement attempt the facility "used its policy" to make a determination if a resident required a	F 689		

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wander guard or Code Alert. The DON stated the policy directed if a resident made statements indicating they wanted to get out, or if they had documented attempts to get out, or if there was some present delirium that the resident had. In the case of R45, he was not saying things like "I gonna walk outta here", and he had no prior elopement attempts, although he is able to propel self in the hallway, R45 and no delirium, and added we felt at the time R45 was not meeting the criteria to have a wander guard. The DON stated the nurse manager did a trial reduction, she removed the wander guard and were observing his behaviors, and we wanted to have the least restrictive environment for him. The DON acknowledged and stated there was no formal documentation or assessment of the determination to remove R45's wander guard, but we did review R45's progress notes, and reviewed the MDS in January that indicated he was not exit seeking. The DON stated she expected all staff to be caring for the resident, know their plan of care and how to care for them, and know to to keep them safe and comfortable.

A facility policy, Code Alert System, last revised 11/30/17, indicated the facility does not have a secure unit, and residents who are at high risk for elopement may not be admitted to the facility. Further, current residents who begin displaying frequent exit seeking behaviors will be evaluated for appropriateness of placement. The policy indicated the purpose of the Code Alert System was to alert staff when a resident is either leaving unit or attempting to leave building via the designated doors. The policy directed in section A: The interdisciplinary care plan team will meet to determine the needs of each resident. Appropriate interventions for wandering, exit

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F 689	Continued From page 83 seeking behaviors will be identified such as redirection, environmental changes, every 30 mint checks. Further the policy directed determination of the Code Alert based upon: 1. Verbal statements of plans to leave building; 2 . Attempts to exit building; and 3. Acute episodes of delirium. A new policy, Wandering, Unsafe Resident, undated, indicated the facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopements. The policy directed staff will identify res who are at risk for harm because of unsafe wandering, including elopement, and the staff will will assess at risk residents, and also the resident's care plan will indicate the resident is at risk for elopement of other safety issues.	F 689		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.	F 732		7/2/18

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(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to consistently post the census on the nurse staff posting. This had the potential to effect all 117 residents residing in the facility and/or visitors who may wish to view the information.

Findings include:

On 5/20/18, at 1:11 p.m. the facility nurse staff posting was observed on the wall near the front entrance. The nurse staff posting indicated a census of 117 and included information on scheduled shifts for nursing staff along with the number of staff assigned to the shift with total hours worked.

The nurse staff posting's were reviewed from

Staffing Coordinator has been retrained to add Census to report each day. In the absence of the Staffing Coordinator, a Nurse Unit Manager will add this information.

Training has been completed.

Policy and procedure was developed.

An audit will be conducted two days per week to ensure compliance.

Findings will be reported at the QAA meeting every two months.

Administrator and Director of Nursing are responsible for ensuring compliance.

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F 732	Continued From page 85 2/21/18, through 5/22/18. The facility census was not recorded on the following 24 days: 3/3/18, 3/4/18, 3/5/18, 3/6/18, 3/7/18, 3/8/18, 3/15/18, 3/16/18, 4/3/18, 4/13/18, 4/23/18, 4/28/18, 4/29/18, 4/30/18, 5/1/18, 5/4/18, 5/7/18, 5/9/18, 5/11/18, 5/12/18, 5/13/18, 5/15/18, 5/17/18 and 5/22/18. During interview on 5/24/18, at 2:52 p.m. the staffing coordinator (SC) stated she filled out the nurse staff posting; however left the census blank, as the night nurse was responsible to pull the current census data and record it on the nurse staff posting. Further, SC stated recording of the census was frequently missed and was not sure who she should speak to about it. On 5/24/18, at 2:59 p.m. the administrator stated her expectation was have the census recorded and posted daily on the nurse staff posting form. A policy was requested and was not received.	F 732		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement behavior interventions for 1 of 2 residents (R91) reviewed who had behaviors related to dementia.	F 744	The care plan for R91 has been updated to include individualized approaches identified. Staff on the unit of been trained on these individualized approaches.	7/6/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 744	Continued From page 86 Findings include: R91's admission Minimum Data Set (MDS) dated 5/1/18, identified severe cognitive impairment with verbal behaviors four to six times but less than daily. The behaviors had no impact on others. A diagnosis of Alzheimer's disease was identified. R91 had a Discharge Return Anticipated MDS completed on 5/7/18. On 5/15/18 R91 re-entered the facility. R91 had a significant change MDS in progress. R91's Admission/Readmission Assessment and Initial Care Plan dated 5/15/18, identified R91 was re-admitted to the facility on 5/15/18, at 1:50 p.m. It did not include behavior interventions. During interview on 5/20/18, at 5:14 p.m. family member (FM)-D stated his mother had a lot of behavioral issues related to her dementia and placement in over 10 facilities since October 2017. He stated he was in the facility visiting his mother on 5/20/18, because the nurse called and said she was having a lot of behaviors and the "state" walked in and they needed him to come sit with his mother. FM-D stated he was willing to come sit with his mother if it helped but felt the staff did not attempt to redirect her. He added the facility liked having residents with memory issues, but not behavioral issues. He stated he even had a personal caregiver come sit with her four to five hours a day. During observation on 5/22/18, at 7:07 a.m. R91 was lying in bed with bare feet yelling out hurry up, get my shoes on. There was not any staff in the room. Nursing assistant (NA)-K walked by R91's room and heard her yelling and entered R91's room and did not introduce herself to R91.	F 744	All residents with written diagnoses of dementia an exhibiting behaviors, were reviewed to ensure care plans reflected individualized person-centered approaches in order to provide the highest quality of dementia sensitive care. Dementia training and the need to utilize resident specific interventions will be conducted for all facility staff. Relias training assigned for staff beginning June 18, 2018. This training will be in addition to routine annual dementia training. An audit will be conducted weekly of two staff per unit providing care to residents diagnosesd with dementia. Findings will be reported at the QAA meeting every two months. Nurse Unit Managers will be responsible for ensuring compliance.	

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R91 asked her where her shoes were and NA-K showed her the shoes. R91 stated she could just hug her, and asked her not to lose her shoes. NA-K told R91 she would get her up and and get her shoes on but needed to get her socks and pants on first. R91 became distressed repeatedly asking for her shoes then stated "god dammit, I want my shoes. You're not making me happy at all." NA-K proceeded to obtain R91's clothing but did not put on her shoes. NA-K told R91 she needed to get some help to transfer her and left the room.

At 7:13 a.m. NA-K and NA-L returned to the room and NA-K finished putting socks, pants and shoes on R91. NA-K and NA-L put the harness and leg straps on R91 to transfer her using the mechanical standing lift. Neither nursing assistant explained what they were doing but continued to hook her to the mechanical lift. During the process R91 stated multiple times she hated the facility. Both NA-K and NA-L laughed out loud. R91 then repeatedly asked where her children were, over and over in a continuous loop. NA-L stated FM-D they would be at the facility around 9:30 a.m.

NA-K and NA-L stood R91 in the standing lift and stated they were bringing her to the bathroom. They started moving the lift towards the bathroom and R91 yelled "No, god dammit, I don't have to go." She just wanted a new pad. NA-L stated lets see if you have to go. R91 continued to be adamant about not wanting to go into the bathroom. Both NA-K and NA-L brought her into the bathroom. NA-L stated lets get you washed up and get a new pad on. R91 continued to say she didn't need to go to the bathroom.

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While in the bathroom NA-K started removing R91's incontinent brief without explaining what she was going to do first and started washing her buttom and perinium with a washcloth. R91 continued asking where her pad was. NA-K did not say a word to her. NA-L told R91 that NA-K was working on it. R91 replied, "oh sure", in a sarcastic tone. R91 then started saying again she hated the facility. Neither NA-K or NA-L tried to redirect R91 during this time.

R91 then started to yell and wanted her lipstick. NA-L replied, after we wash you up. R91 stated I have been waiting all day. NA-L stated NA-K would do her hair and makeup after she was washed up. NA-K stated "If you wash up, I'll quit," with continueing cares. NA-K removed R91's bra and did not tell R91 she was going to remove it. R91 started screaming not to take her bra off. NA-K told her she had a clean bra for her. R91 asked where it was. NA-K continued dressing R91 without step by step explanation of what NA-K was doing. During this time she repeatedly asked where her children where. Every time R91 asked, her volune and tone increased getting louder. NA-L would just tell her FM-D would be there at 9:30 a.m. Neither NA-K or NA-L attempt to redirect her. R91 continued to get distraught each time she asked for her children and the nursing assistants would answer her.

When NA-L moved the lift in the bathroom to transfer R91 to her wheelchair she started screaming not to put her in the shower. There was a shower in R91's room. NA-L stated she wasn't going to give her a shower. R91 kept saying to staff who are you what are you doing, as they were transferring her to her wheelchair. NA-K would tell R91 who NA-L was and NA-L

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would laugh out loud. No explanation was given to R91 before NA-K and NA-L moved the lift. After the transfer NA-L left the room.

While in the wheelchair in the bathroom. NA-K assisted R91 with brushing her teeth and putting on make-up. NA-K handed R91 a light pink lipstick R91 put on the lipstick. R91 started yelling she needed lipstick because it was so light in color she could not see it. NA-K apologized and said she gave her the wrong colored lipstick, she should have given her a darrker one as she had become upset previously when given the light colored lipstick. At 7:38 a.m. NA-K brought R91 to the dining room via wheelchair.

On 5/22/18, at 7:59 a.m. R91 was lying in bed per her request. She put her call light on and licensed practical nurse (LPN)-D entered her room but did not introduce herself. R91 started yelling who are you and what are you doing. LPN-D stated she was the nurse. R91 wanted to know what time FM-D was coming. LPN-D stated FM-D was on vacation so she would give FM-E a phone call. LPN-D stated out loud "I'm not fast enough for her," as R91 put on her call light again. At 8:04 a.m. LPN-D came back to R91's room and stated she left a message for FM-E to call. The telephone rang and LPN-D answered, it was FM-E. LPN-D told R91 that FM-E would be in to see her between 9:00 a.m. and 9:30 a.m. and left the room. Between 8:08 a.m. and 8:14 a.m. R91 turned her call light on several times. LPN-D answered and stated FM-E was on her way as R91 wanted to know when she was coming. At no time did LPN-D offer R91 any sort of distraction while she waited for FM-E to visit.

At 9:20 a.m. R91 put on her call light. NA-L

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answered her light and told her FM-E was on his way and left the room. At 9:21 a.m. R91 put her light on again and LPN-D answered the call light. R91 asked when FM-D was going to be coming. LPN-D stated FM-D was on vacation and FM-E would be there shortly.

At 9:23 a.m. R91 put on her call light. NA-L answered it and told her FM-E was on his way. R91 was ok and NA-L left the room. At 9:38 a.m. FM-E arrived and R91 was calm and they talked about new t-shirts that FM-E brought for her.

During interview on 5/22/18, at 1:26 p.m. NA-K stated R91 could be "very difficult" and gets upset and swears at the staff. She frequently repeats herself and asks the same questions even if they had just been answered. NA-K stated R91 seemed to be better when one on one and today there was two getting her ready and it seemed to agitate her more, she had never let nursing know this so it could be care planned. Further, in hindsight she should have just put on R91's shoes right away when she requested them and should have explained cares before doing them that morning. She didn't explain things before because there were two people helping her and she didn't want to confuse and agitate her more. She seemed to get more agitated in the dining room around so many different residents and staff, but they had never talked about eating in a separate area to help calm her. The staff had not been given any instruction on interventions to try to redirect her. NA-K stated R91 can put her call light on 18 times in a half hour and stated "I don't know what to do."

On 5/22/18, at 1:55 p.m. NA-L stated the facility had never instructed the staff on specific

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interventions to deal with R91's agitation and repetitive questioning. She gets very upset and then repeats herself even after the question was answered. She felt cares were a bit rushed today and not explained well to the resident increasing her frustration and agitation. NA-L stated everyone tried to do their own thing with her to calm her but they had not met with the team to discuss what interventions to try and what worked and what didn't. NA-L stated she did not know FM-D was out of town as it was not shared in report otherwise she would have told R91 FM-E was coming instead.

When interviewed on 5/23/18, at 9:46 a.m. registered nurse (RN)-F stated when R91 got really loud she was brought to her room and staff try to calm her; however, there were not specific interventions to try. RN-F stated she was worse in the evening, which was common with Alzheimer's and stated family was frequently called to come sit with her, but that did not always work. Further, R91 tended to respond better with simple direct conversation at her eye level. She had good days and bad days but was not aware of any assessments being conducted to determine what goes right on the days she has her good days or what preceded her behaviors on the bad days.

During interview on 5/23/18, at 10:38 a.m. medical doctor (MD)-A stated R91 was in a bad place with her Alzheimer's disease with likely delirium on top from so many transfers between facilities. She talked to the unit manager about an essential oil diffuser, but was not sure what came of it. She felt R91's pain was controlled and it was not the cause of her yelling and agitation. MD-A stated the staff should be working on non-pharmalogical interventions to help.

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On 5/23/18, at 2:51 p.m. R91's personal caregiver (PC)-A was at the facility visiting R91. R91 was in bed watching television sipping on coffee. She was calm. LPN-C entered the room and said hello to R91. R91 scrunched up her face and asked, what? PC-A told LPN-C to speak slower and face her when you talk. LPN-C did so and R91 responded with a smile and stated she was feeling good. PC-A stated she was at the facility four to five hours a day Monday through Friday and sometimes on the weekends if R91's children were not available. She had worked with R91 for three years and knew her very well. She stated she got very anxious when she didn't know what was happening next, or if people talked too fast and too much. She got confused and it created more anxiety for her. PCA-A stated when R91 got in repetitive conversation loops she was easily distracted by doing crosswords, reminiscing or playing solitaire on her IPad. She stated R91 was a teacher and a world traveler and loved to talked about it and tell stories. She needed reassurance and calm and she usually snapped out of a behavior. PCA-A stated the facility had not asked her input in behavior intervention.

During interview on 5/23/18, at 3:05 p.m. LPN-C stated R91 had a lot of behaviors like trying to crawl out of bed and stated family was frequently called in to assist. There was no planned interventions to try with R91. Further, she thought R91 was calmer when the staff sat and talked with her and gave her compliments.

When interviewed on 5/23/18, at 3:35 p.m. RN-G stated behavior interventions should have been on the initial care plan. The facility had not had a

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care conference with family as it was to be held the day she was admitted to the hospital and had one scheduled for the following week. However, she gets so agitated family should have been consulted before care conference and the initial care plan updated with some interventions prior to care conference and assessment completion. RN-G stated the social worker usually completes behavioral care plans and it should start right away.

On 5/24/18, at 10:34 a.m. licensed social worker (LSW)-B stated she had talked to family on admission related to discharge goals, but was not aware of any behavior issues with R91. Family had brought in an iPad and and stated R91 loved to have her nails and hair done along with liking her lipstick. LSW-B stated she always asked about past history for dementia residents. She further stated staff all received dementia training on hire and at least annually and sometimes they just get so task orientated they don't follow good dementia care practices.

During interview on 5/24/18, at 1:49 p.m. the director of nursing (DON) stated all the staff received dementia training and the next process improvement project for the facility was how to handle difficult residents. Basic dementia care included speaking directly to the residents, giving short answers and explaining tasks before completing them. This was expected and not needed to be part of the care plan. DON stated R91 perseverated about her children and where they were but there were no interventions care planned, as it was not required until day 21 when the comprehensive care plan was completed

A policy on dementia care and behavior

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F 744	Continued From page 94 interventions was requested and not received.	F 744		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 755	Training will be conducted for all nurses	7/2/18

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review, the facility failed to develop and implement policies and procedures to ensure an accurate, documented and traceable system of narcotic reconciliation to rapidly detect potential diversion for 2 of 3 units (500, 400) reviewed for medication storage. This had potential to affect 16 residents who currenlty recieved narcotic and/or controlled substances on these units.

Findings include:

A Order Search listing printed 5/24/18, identified seven residents had current orders for controlled and/or narcotic medications on the 500 unit.

On 5/24/18, at 9:44 a.m. the 500 "West" medication cart was reviewed with licensed practical nurse (LPN)-A. The cart was locked with a physical key, inside the cart, a metallic box was attached which contained the controlled substances and narcotic medications for the residents. A bound black book was used to document each specific resident' medication along with a current amount; along with a steno-style notepad. The notepad was tattered, and the edges were curled. LPN-A explained the narcotic medications were counted with each shift exchange, and staff were to document these counts using the notepad. The notepad was provided and arranged into two columns labeled, "Out," and, "In," respectively, with six signatures being required to satisfy an eight hour shift-to-shift count. Upon review, the notepad identified the following dates:

5/1/18 - six signatures present,
5/2/18 - 10 signatures present,
5/4/18 - six signatures present,
5/5/18 - six signatures present,

and TMA's regarding need to sign proof of count sheet during shift change.

Policy and procedure developed.

An audit will be conducted 3 days per week to verify compliance.
Findings will be reported at the QAA meeting every two months.

Nurse Unit Managers are responsible for ensuring ongoing compliance.

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5/6/18 - six signatures present,
5/7/18 - six signatures present,
5/8/18 - 16 signatures present,
5/11/18 - six signatures present,
5/12/18 - four signatures present,
5/13/18 - 18 signatures present,
5/16/18 - 12 signatures present,
5/18/18 - 20 signatures present,
5/21/18 - two signatures present,
5/22/18 - six signatures present,
5/23/18 - two signatures present and,
5/24/18 - four signatures present.

There was no documentation present or provided to demonstrate any counting of the narcotics had been completed on 5/3/18, 5/9/18, 5/10/18, 5/14/18, 5/15/18, 5/17/18, 5/19/18, or 5/20/18.

When interviewed immediately following, LPN-A stated "people aren't dating" when they are counting the cart. LPN-A explained she was able to recognize the signatures of the nurses and felt the cart was being counted, just not documented correctly adding if someone didn't recognize the signatures it would be "very confusing" trying to determine who last had the narcotic keys. LPN-A added there "probably needs to be a better thing than a crumpled notepad," to document the narcotic counts on adding this had been the facility practice for awhile, and was used on all medication carts to her knowledge.

During this time the surveyor and LPN-A completed a total narcotic count for all the medications in the cart, and all counts were accurate with no medications missing for the 500 unit medication carts.

F 755

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An Order Search listing printed 5/24/18, identified nine residents had current orders for controlled and/or narcotic medications on the 400 unit.

On 5/24/18, at 10:08 a.m. the 400 "South" was reviewed with registered nurse (RN)-A. The cart was locked with a physical key, and inside a metallic box was attached which contained the controlled substances and narcotic medications for the residents. A bound black book was used to document each specific resident' medication along with a current amount; along with a steno-style notepad. Again, the notepad was tattered, and the edges were curled being held with a spiral top and rubber band. RN-A stated the narcotics should be counted every shift and documented accordingly in the notepad. The notepad was again separated into two columns, however, neither of the sides were labeled. It contained various dates and signatures to demonstrate the narcotic count for the followoing dates:

5/1/18 - six signatures present,
5/2/18 - eight signatures present,
5/3/18 - six signatures present,
5/4/18 - 12 signatures present,
5/6/18 - six signatures present,
5/7/18 - 12 signatures present,
5/8/18 - two signatures present,
5/9/18 - four signatures present,
5/10/18 - 14 signatures present,
5/11/18 - four signatures present,
5/13/18 - four signatures present,
5/14/18 - 12 signatures present,
5/16/18 - 20 signatures present,
5/20/18 - six signatures present,
5/21/18 - six signatures present,

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F 755	Continued From page 98	F 755		

5/22/18 - six signatures present,
5/23/18 - six signatures present and,
5/24/18 - three signatures present.

There was no documentation present or provided to demonstrate any counting of the narcotics had been completed on 5/5/18, 5/12/18, 5/15/18, 5/17/18, 5/18/18, or 5/19/18.

When interviewed immediately following, RN-A stated she felt staff were just entering the "dates wrong," but added she was "100% sure they [staff] counted." Staff had been using this system with the notepads for a "long time" and if the counts were off, they would immediately report it to the nurse supervisor.

During interview on 5/24/18, at 11:32 a.m. the director of nursing (DON) stated nurses should be counting the narcotics and controlled substances at the end of every shift with the exchange of keys. DON reviewed the notepad sheet(s) and stated "what they [staff] lacked" was signing it off in the book, however, she was certain they were counting the carts and just "missed some signing." DON stated she felt pulling the schedules to determine who last worked would be "just as rapid" to detect potential diversion, however, added the consulting pharmacist (CP)-A was never included in development of this system to her knowledge. DON stated she could converse with CP-A to see if a better system could be used. Further, DON stated she did not think CP-A completed any routine audits of the medication carts, at least since she had been hired in October 2017.

Medication cart audits were requested, however, none were provided.

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F 755	Continued From page 99 A telephone interview was attempted with the routine consulting pharmacist (CP)-A, however, they were not available. On 5/24/18, at 2:14 p.m. a telephone interview was completed with CP-B whose was the identified person filling in for CP-A. CP-B stated he could not answer facility-specific policy or practice questions as he was located in Milwaukee, Wisconsin and did not routinely travel to the facility. However, CP-B stated CP-A should be completing a monthly review and "spot check" of medication storage practices, including controlled substance monitoring, and giving the report to the DON. A facility Controlled Substances policy dated 12/2012, identified the facility shall comply with all laws, regulations, and other requirements related to the handling, storage and documentation of schedule II and controlled substances. The policy listed its reference to F431 (old regulation which expired 11/28/17), however, directed nursing staff must count controlled substances at the end of each shift and "...must document and report any discrepancies to the [DON]." The policy lacked any direction or guidance on how to document these counts.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758		7/6/18

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F 758	Continued From page 100 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758		

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F 758

Continued From page 101

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and document review the facility failed to provide non-pharmalogical intervention prior to administration of as needed (PRN) antipsychotic medication prior for 1 of 1 residents (R91) reviewed for PRN psychotropic medication use.

Findings include:

R91's admission Minimum Data Set (MDS) dated 5/1/18, identified R91 had severe cognitive impairment, with verbal behaviors four to six times but less than daily. The behaviors had no impact on others. A diagnosis of Alzheimer's disease was identified.

R91's Admission/Readmission Assessment and Initial Care Plan dated 5/15/18, identified R91 was re-admitted to the facility on 5/15/18, at 1:50 p.m. It included a review of medication. It did not include use of an antipsychotic (mood alternating medication) medication, target behaviors or specific interventions related to behaviors.

R91's physician orders identified the following:

- Seroquel (antipsychotic) 6.25 milligrams (mg) by mouth (po) every 6 hours PRN ordered 5/15/18, through 5/21/18, for agitation.

- Seroquel 12.5 mg po every 6 hours PRN ordered 5/21/18, for 14 days for agitation.

R91's May 2018, Medication Adminstration Record (MAR) identified the following:

- Target behaviors for giving the PRN Seroquel

F 758

The care plan for R91 has been updated to include individualized approaches identified. Staff on the unit of been trained on these individualized approaches.

All other residents receiving PRN antipsychotic medications were reviewed to ensure pro active non pharm interventions were in place.

Dementia training and the need to utilize resident specific interventions will be conducted for all facility staff.

Relias training assigned for staff beginning June 18, 2018. This training will be in addition to routine annual dementia training. PCC updates will be made to record non-pharmacological interventions prior to utilizing PRN psychotropic medication.

Weekly audits will be conducted of 10% of residents receiving PRN psychotropic medications to ensure non-pharmacolocial approaches attempted first.

Findings will be reported at the QAA meeting every two months.

Nurse Unit Managers will be responsible to ensure ongoing compliance.

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Continued From page 102
included yelling out, swearing, striking out at staff, that cannot be redirected. The MAR did not provide interventions prior to giving the Seroquel.

- R91 received 6.25 mg of Seroquel six times 5/15/18, through 5/20/18. The MAR did not identify any non- pharmacological interventions attempted prior to giving the Seroquel.

- R91 received 12.5 mg of Seroquel one time on 5/21/18. The MAR did not identify any non-pharmacological interventions tried before giving the Seroquel.

R91's Orders Administration Note (s) from 5/15/18, through 5/20/18, did not identify interventions attempted prior to administrating the PRN Seroquel.

During observation on 5/20/18, at 5:12 p.m. R91 was seated at the dining room table with family member (FM)-D. R91 was calm, smiling and had no visible side effects.

During interview on 5/22/18, at 1:26 p.m. nursing assistant (NA)-K stated R91 had behaviors of yelling out and repeatedly called out asking where family was. R91 was never physically aggressive, but the yelling out bothered other residents on the unit. NA-K stated the facility had not instructed the nursing assistants on specific interventions for yelling out.

On 5/22/18, at 1:55 p.m. NA-L stated the facility had never instructed the nursing assistants on specific interventions to try when R91 was yelling out and becoming agitated.

When interviewed on 5/23/18, at 9:46 a.m.

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F 758	Continued From page 103	F 758		

registered nurse (RN)-F stated R91's Target behaviors were listed on the MAR; however, there were no specific interventions related to the target behaviors to attempt prior to administrating PRN Seroquel. RN-F stated R91 yelled, and frequently swore, and was very repetitive which made her more anxious and if she got louder and couldn't be calmed, family was called to give permission to give the Seroquel. RN-F stated interventions should be directed and documented what was tried before the Seroquel was given; however, it had not been documented.

On 5/23/18, at 10:38 a.m. medical doctor (MD)-A stated R91 was placed on PRN Seroquel at FM-D's request while hospitalized. She increased the dose as it was not effective and thought it was too low of an original dose to evaluate it's effectiveness properly. She stated non-pharmalogical interventions should be tried first before giving the Seroquel.

During interview on 5/23/18, at 3:05 p.m. licensed practical nurse (LPN)-C stated she tried to redirect R91 prior to calling family to get permission to administer Seroquel; however there were not specific interventions to try. LPN-C stated interventions tried were not being documented prior to the administration of the Seroquel.

When interviewed on 5/24/18, at 1:49 p.m. the director of nursing (DON) stated she expected interventions attempted prior to giving the Seroquel to be documented along with their effectiveness. R91 was in process of a significant change MDS and interventions would be added when the comprehensive care plan was completed.

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F 758	Continued From page 104 A policy was requested and not received.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure tuberculin solution was dated when opened to ensure expired product was not administered on 2 of 3 units (500, 400) reviewed for medication storage. This had potential to affect 19 of 19 residents who	F 761	All nurses have received education regarding the need to label vials whenever opened. Training will be provided to all nurses prior to July 2, 2018.	7/2/18

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F 761	Continued From page 105 could be provided the remaining, potentially expired solution. Findings include: A PAR Pharmaceutical APLISOL manufacturer insert dated 08/14, identified the solution was used for intradermal injection(s) to help determine the presence of tuberculosis (an infectious agent). The insert provided storage instructions for the medications including bold lettering describing, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." On 5/24/18, at 9:44 a.m. a tour was completed of the 500 unit medication room with licensed practical nurse (LPN)-A. A Whirlpool refrigerator was inspected which contained two opened boxes, and subsequently opened vials, of PAR Pharmaceutical Aplisol Tuberculin derivative. The boxes identified each vial contained enough product for "10 Tests," and each of the opened vials had visible solution remaining inside. A pharmacy placed label was affixed which identified the solution name, along with a 'fill' date on the label printed as 4/16/18. However, neither the boxes or vials of opened solution were dated to demonstrate a date which they were opened and/or set to expire. LPN-A reviewed both of the vials and stated one vial had "half a bottle" left of solution with the other vial having "just one dose" or so used. LPN-A stated a total of six doses appeared to have been used between both of the vials, and verified the lack of dating on the boxes or labels to demonstrate when they had been opened, or to reflect when they would expire. LPN-A explained	F 761	A weekly audit will be conducted of all vials to ensure dating. Findings will be reported at the QAA meeting every two months. Nurse Unit Managers are responsible for ensuring ongoing compliance.	

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F 761	Continued From page 106	F 761		

the solution inside the vials was used to give tuberculin skin tests on residents, and staff were supposed to date them when opened to ensure they were used within 30 days in accordance with manufacturer instructions. LPN-A expressed using undated solution could cause an elevated "risk of bacteria" as they were multi-dose vials, and she would immediately discard both of the vials "to be safe." Further, LPN-A stated staff were trained to date medication vials "all the time."

On 5/24/18, at 10:17 a.m. the 400 unit medication room refrigerator was inspected with registered nurse (RN)-A. Two opened boxes, and subsequently opened vials, of Aplisol solution were inside. Each of these vials were identified as being filled by the pharmacy on 4/16/18, however, only one of the vials was dated when opened on 4/29/18. The other vial lacked any visible dating to demonstrate when it was opened and/or when it would expire. RN-A verified the vial was undated and stated it had "five doses" of solution left. Further, RN-A stated the vial should of been dated when it was opened in order to "make sure its not expired" when administered.

A total of 19 doses of medication were available to be administered according to the interview(s) completed with LPN-A and RN-A.

When interviewed on 5/24/18, at 11:32 a.m. the director of nursing (DON) stated the multi-use vials should have been dated when they were opened and added, "that would be the expectation."

A telephone interview was attempted with the routine consulting pharmacist (CP)-A, however,

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F 761	Continued From page 107 they were not available. On 5/24/18, at 2:14 p.m. a telephone interview was completed with CP-B who was the identified person filling in for CP-A. CP-B stated multi-dose vials "generally" should be dated when opened for infection control purposes adding it was their pharmacy recommendation to discard them after 30 days. A facility policy on dating multi-use vials was requested, however, none was provided.	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		7/2/18

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F 880	Continued From page 108 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 109 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete a comprehensive risk assessment to reduce the risk of Legionella (a bacterium) within the facility's water system to prevent potential cases and outbreaks of Legionnaires' disease (a serious type of pneumonia). This had the potential to effect all residents in the facility. Findings include: Review of the facility policy, entitled: Legionella Water Management Program (undated), the policy indicated under section 4 (control measures) the facility listed physical plant areas of concern for Legionella harbor and growth, such as, "sinks/showers" for "lack of disinfection" and "stagnation". In section 5 (confirmatory procedures and verification steps) - the facility indicated that "annual testing will be done to all control points." On 5/24/18 at 10:20 a.m., when asked about the Legionella policy, the director of nursing stated that the director of environmental services (DES) should be interviewed for questions on the Legionella policies. In an interview on 05/24/18, at 10:23 a.m. (DES) stated the facility just formulated the policy during the last several months. DES stated last Fall, the facility replaced several water system mixing valves, so water temperatures within the system could be maintained per the recommendations of the Centers of Disease Control (CDC). DES stated the facility had been in contact with the local city of Elk River, for their water system	F 880	A water sample has been sent to an approved laboratory for testing, now and will be completed annually going forward. A yearly audit will be conducted to ensure compliance. Findings will be reported at the QAA meeting annually. The Maintenance Director will be responsible for ensuring ongoing compliance.	

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F 880	Continued From page 110 testing process, but had yet to heard back. DES stated that the facility had not yet culture/test the facility's water system for Legionella. DES stated that the infection control nurse and the facility administrator have also been working on the policy. During an interview on 5/24/18, at 10:54 a.m., administrative nurse / infection advisor (IC) stated he was new to the infection control position (starting on 5/1/18), and did not know until this week, that he was on the Legionella team. IC was unaware if the facility's water had been tested. In a final interview on 05/24/18, at 11:06 a.m. the facility administrator stated that DES started working on the facility policy and physical plant changes last Fall 2017, with the policy being completed "3-4 weeks ago." Even though they had received information from a testing company in New Ulm, MN, the facility had not contacted this service nor contacted another company for testing of the facility's water system.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Guardian Angels Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/20/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	05/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE** **ELK RIVER, MN 55330**

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K 000	Continued From page 1	K 000		

444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:
Marian.Whitney@state.mn.us
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.

Guardian Angels Care Center is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1974 a single story addition was constructed to the East Wing and determined to be of Type II (111) construction. Also, in 1995 an addition was constructed to the East Wing and determined to be of Type II (111). Another addition was constructed in 2007 to the Northeast Wing and determined to be Type V (111) with a 2 hour separation.

The building is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**05/22/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE** **ELK RIVER, MN 55330**

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K 000	Continued From page 2 open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 117 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 133 SS=E	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This **REQUIREMENT** is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the protective rating in one 2 hour fire barrier as listed in the Life Safety Code **NFPA 101** 2012 edition, section 8.2.1.3. This deficient practice could cause fire to spread more quickly through a compartment and affect 18 of the 120 residents and an undetermined amount of staff and visitors.	K 133	Hole has been fire caulked shut. All subcontractors who may do work related to fire wall integrity will be required to repair any holes promptly. Maintenance will review wall integrity after any work is completed. Director of Maintenance will be	7/2/18

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	245012	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

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K 133	Continued From page 3 Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed a 1 1/2 inch hole in the 2 hour fire barrier connecting the 2007 edition near the 500 wing, above the ceiling in the wall adjacent to the cross corridor doors. This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor.	K 133	responsible for ongoing compliance.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This **REQUIREMENT** is not met as evidenced by: Based on observation and staff interview the facility failed to provide the level of lighting as required by the Life Safety Code, (NFPA 101) 2012 edition section 7.8.1.4. This deficient practice could reduce the illumination of the exits and affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed the exterior light on the exit discharge at the end of wing 200 had only one bulb for illumination.	K 281	Lighting fixture was replaced with an LED fixture. Exterior lights are on quarterly preventative maintenance checks. Any discrepancies are reported to the Director of Maintenance. Director of Maintenance will be responsible for ensuring compliance.	7/2/18

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	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/22/2018**

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GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE** **ELK RIVER, MN 55330**

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K 281	Continued From page 4 This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor.	K 281		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the	K 321	The closer has been adjusted on this	7/2/18

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K 321	Continued From page 5 facility failed to maintain one hazardous storage room and one combustible storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed the soiled utility room in the lower level next to the laundry did not latch when tested and the combustible storage area adjacent to the activity room, in the 1965 wing, is not separated to resist the passage of smoke. This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor.	K 321	door, and it is functioning properly. All doors are inspected annually to ensure proper function. Director of Maintenance will be responsible for ongoing compliance.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.	K 341		7/2/18

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	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/22/2018**

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K 341	Continued From page 6 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 36 of the 120 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed a smoke detector within 36 inches of an HVAC diffuser in the 100 wing in front of the cross corridor doors. This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor	K 341	The smoke detector has been moved to a new location that is greater than 36 inches from the HVAC. An house-wide audit was completed and any other smoke detectors that were noted were moved to an appropriate distance from the HVAC. Director of Maintenance is responsible for ongoing compliance.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		7/2/18

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	245012	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 7 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. 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 REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide one set of corridor doors with a means suitable for keeping the door closed in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in case of a fire,	K 363	A slide bolt and latch set was added to the door. All closet and supply doors were audited and changes were made if necessary. Director of Maintenance is responsible for	

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	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/22/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 8 affecting an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed the storage room doors in the 200 wing contained roller latches. This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor	K 363	ongoing compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a	K 918		7/2/18

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	245012	A. BUILDING **01 - MAIN BUILDING 01** B. WING ________	**05/22/2018**

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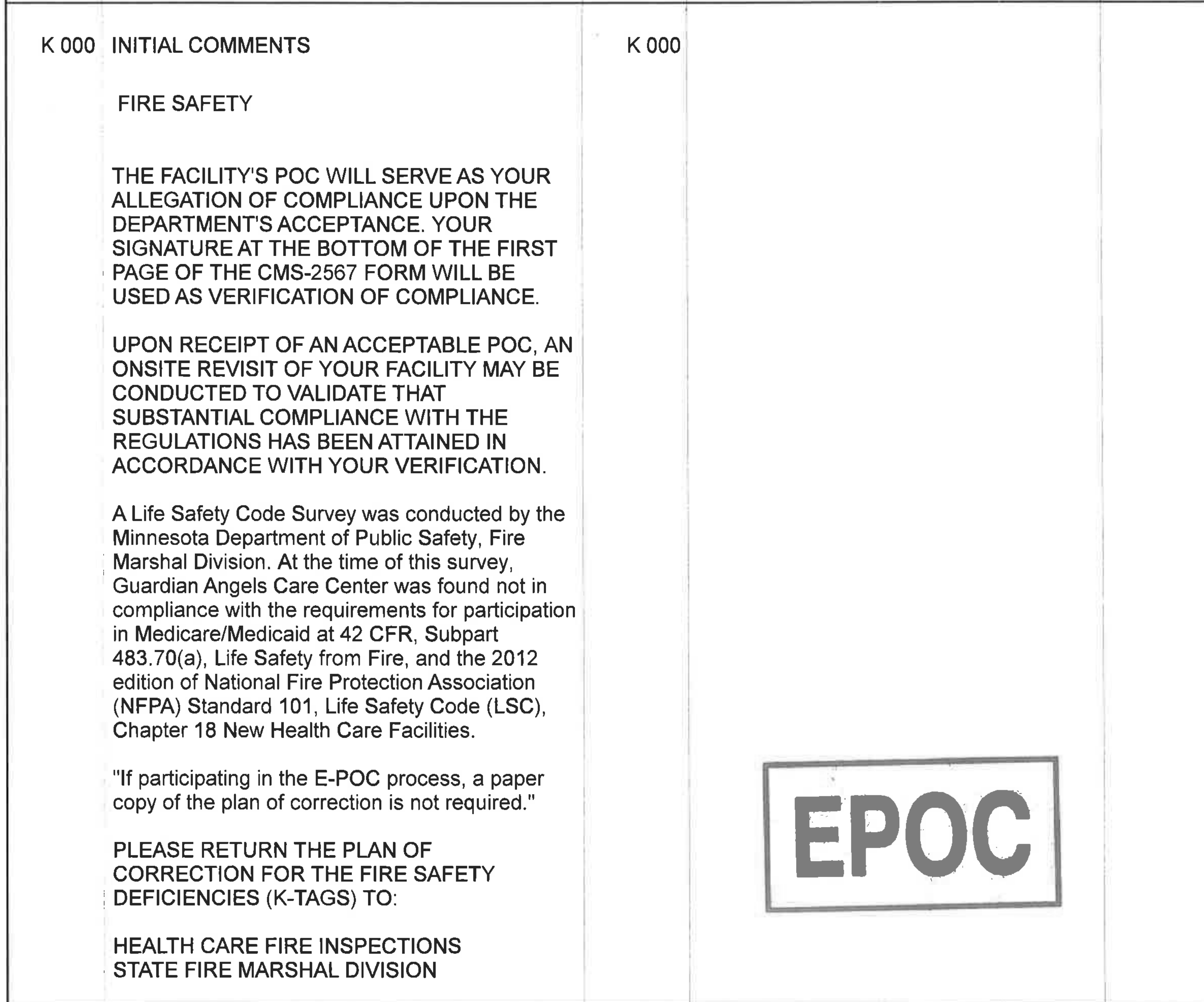
K 918	Continued From page 9 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the generator safety features were in compliance with the 2010 edition of NFPA 110 section 5.6.5.6. This deficient practice could cause the premature failure of the generator which could affect all 120 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed the emergency shut off button on the generator was not located outside of the enclosure. This deficient conditions was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 918	Remote emergency shut switches have been installed on the outdoor emergency generators. Emergency Plan was reviewed and updated regarding the addition of the switches. Quarterly monitoring to ensure switches are intact has been added to our preventative maintenance program. Results will be communicated in QAA meeting. Maintenance Director will be responsible for this.	

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

F5012027

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING ________	**05/22/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE** **ELK RIVER, MN 55330**



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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

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

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Guardian Angels Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Facilities.

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/20/2018

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	245012	A. BUILDING 02 - GUARDIAN ANGELS CARE CENTER B. WING ______	05/22/2018

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K 000	Continued From page 1 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us 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. Guardian Angels Care Center is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1974 a single story addition was constructed to the East Wing and determined to be of Type II (111) construction. Also, in 1995 an addition was constructed to the East Wing and determined to be of Type II (111). Another addition was constructed in 2007 to the Northeast Wing and determined to be Type V (111) with a 2 hour separation. The building is fully sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces	K 000		

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	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING	**05/22/2018**

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K 000	Continued From page 2 open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 120 beds and had a census of 117 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		7/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING ______	**05/22/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	**400 EVANS AVENUE** **ELK RIVER, MN 55330**

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K 321	Continued From page 3 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous storage room and one combustible storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 18.3.2.1. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 18 of 120 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed the soiled utility room in the 500 wing did not have a fire rated door. This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor.	K 321	The storage room door on the 500 unit has been ordered and will be installed as soon as it arrives. Director of Maintenance is responsible for ongoing compliance.	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment.	K 341		7/2/18

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	245012	A. BUILDING 02 - GUARDIAN ANGELS CARE CENTER B. WING	05/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS CARE CENTER	400 EVANS AVENUE ELK RIVER, MN 55330

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K 341	Continued From page 4 Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 18.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 36 of the 120 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed a smoke detector within 36 inches of an HVAC diffuser in resident rooms 413, 415, 510 and the two in front of the nurses station in wing 500. This deficient condition was confirmed by the facility Administrator and the Maintenance Supervisor	K 341	The identified smoke detectors have been moved to a new location that is greater than 36 inches from the HVAC. An house-wide audit was completed and any other smoke detectors that were noted were moved to an appropriate distance from the HVAC. Director of Maintenance is responsible for ongoing compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying	K 918		7/2/18

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	245012	A. BUILDING **02 - GUARDIAN ANGELS CARE CENTER** B. WING ______	**05/22/2018**

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K 918	Continued From page 5 service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the generator safety features were in compliance with the 2010 edition of NFPA 110 section 5.6.5.6. This deficient practice could cause the premature failure of the generator which could affect all 120 residents and an undetermined amount of staff and visitors.	K 918	Remote emergency shut switches have been installed on the outdoor emergency generators. Emergency Plan was reviewed and updated regarding the addition of the switches. Quarterly monitoring to ensure switches are intact has been added to our preventative	

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K 918	Continued From page 6 Findings include: On the facility tour between 8:30 am to 1:00 pm on 05/23/2018 observations revealed the emergency shut off button on the generator was not located outside of the enclosure. This deficient conditions was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 918	maintenance program. Results will be communicated in QAA meeting. Maintenance Director will be responsible for this.	