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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 813H

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00017

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245397**
2.STATE VENDOR OR MEDICAID NO.
(L2) **255822000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVENWOOD CARE CENTER**
(L4) **1633 DELTON AVENUE**
(L5) **BEMIDJI, MN** (L6) **56601**

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 **05/18/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 90 | | | |
| (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 :
Theresa Gullingsrud, HFE NEII 09/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/05/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**05/18/2017**
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5397

On May 18, 2017, the Departments of Health and Public Safety completed revisits to verify correct of deficiencies issued pursuant to the March 23, 2017 standard survey. Based on the revisits the facility achieved compliance, effective May 2, 2017.

As a result of the revisit findings, the Category 1 remedy of State monitoring has been discontinued.

In addition, the following enforcement remedy has been rescinded:

- Mandatory denial of payment for new Medicare and Medicaid Admissions (DPNA).

Since DPNA did not go into effect, the two year loss of NATCEP is also rescinded.

Furthermore, the Department recommended to the CMS Region V office that the following enforcement remedy be imposed:

- Civil money penalty for deficiency cited at F323.

Effective May 2, 2017, the facility is certified for 90 skilled nursing facility beds.

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

CMS Certification Number (CCN): 245397

September 5, 2017

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

Dear Mr. Bjerke:

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 May 2, 2017 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Electronically delivered
September 5, 2017

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

RE: Project Number S5397027

Dear Mr. Bjerke:

On April 10, 2017 and May 25, 2017, as authorized by the CMS Region V Office, the Department informed you that the following enforcement remedies were being imposed:

- State Monitoring effective April 15, 2017. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 23, 2017. (42 CFR 488.417 (b))

Further, the Department notified you in our letter of May 25, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 23, 2017.

Furthermore, we recommended to the CMS Region V Office the following additional enforcement remedy for imposition:

- Civil money penalty for deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on March 23, 2017, and lack of verification of compliance of the health and life safety code deficiencies, at the time of our May 25, 2017 notice. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On May 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 17, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2017. Based on our visits, we determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 23, 2017, effective May 2, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring as of May 2, 2017

In addition, the Department recommended to the CMS Region V Office the enforcement action as it relates to the remedy in our letter of May 25, 2017. CMS Region V Office concurs, and has authorized this Department to notify you of the following:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 23, 2017, be rescinded. (42 CFR 488.417 (b))

Further, in our letter of May 25, 2017, 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 June 23, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 2, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Furthermore, the Department is recommending the following enforcement action related to the remedy recommended in our letters of April 10, 2017 and May 25, 2017:

- Civil money penalty for deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedy and appeal rights.

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
September 5, 2017

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

Re: Reinspection Results - Project Number S5397027

Dear Mr. Bjerke:

On May 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 23, 2017. At this time, these correction orders were found corrected.

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 25, 2017

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

RE: Project Number F5397026, S5397027

Dear Mr. Bjerke:

On April 10, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 15, 2017. (42 CFR 488.422)

In addition, on April 10, 2017, the Department informed you that we were recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on March 23, 2017. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On May 17, 2017, the Minnesota Department of Public Safety a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2017. Based on our visit, we have determined that your facility has achieved compliance with the life safety code deficiencies issued pursuant to our standard survey, completed on March 23, 2017.

However, compliance with the health deficiencies issued pursuant to the March 23, 2017 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

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

In addition, this Department recommended to the CMS Region V Office the following action related to the remedy recommended in our letter of April 10, 2017:

- Civil money penalty for deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 23, 2017. (42 CFR 488.417 (b))

Also, 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, Havenwood Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 23, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 23, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 23, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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

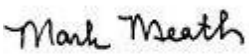
## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 23, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

Sincerely,



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

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 813H

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00017

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245397**

2.STATE VENDOR OR MEDICAID NO.
(L2) **255822000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVENWOOD CARE CENTER**
(L4) **1633 DELTON AVENUE**
(L5) **BEMIDJI, MN** (L6) **56601**

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 **03/23/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
**X** A. In Compliance With Program Requirements
Compliance Based On:
**X** 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 90 | | | |
| (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 :
Theresa Gullingsrud, HFE NE II 05/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 05/17/2017 (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
**12/01/1986**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5842

April 10, 2017

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, Minnesota 56601

RE: Project Number S5397027

Dear Mr. Bjerke:

On March 23, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

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

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

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

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

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

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

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

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

## 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 April 15, 2017. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

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

## PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 23, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 23, 2017 (six months after the

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. 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 related to this letter.

Sincerely,

Mark Meath

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

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

Enclosure(s)

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 |
|---|---|---|---|
| | 245397 | A. BUILDING _____ B. WING _____ | 03/23/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP,CODE |
|---|---|
| HAVENWOOD CARE CENTER | 1633 DELTON AVENUE BEMIDJI, MN 56601 |

| (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 |
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| F 000 | INITIAL COMMENTS<br><br>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.<br><br>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 225 SS=D | 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>483.12(a) The facility must-<br><br>(3) Not employ or otherwise engage individuals who-<br><br>(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;<br><br>(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or<br><br>(iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. | F 225<br><br>LB w/addendums 5/1/17 | **F 225**<br><br>R64's fall dated 3/2/2017 was reported to the SA on 4/20/2017. The Disposition Letter from MDH was received on 4/26/17 stating that the information has been reviewed and it has been determined that no further action by this office is necessary at this time.<br><br>All incidents of potential abuse/mistreatment and/or neglect will be reported to the SA immediately.<br><br>The Abuse Prevention/Prohibition Program was reviewed on 4/20/2017. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Brandi Bjerke | Administrator | 4-26-17 |

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

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| F 225 | Continued From page 1<br>(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.<br><br>(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>(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.<br><br>(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.<br><br>(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 | F 225 | Education will be provided to all charge nursing staff regarding Vulnerable Adult reporting requirements for unwitnessed falls resulting in injury.<br><br>The Administrator or designee will audit all falls to ensure proper reporting protocols are followed.<br><br>Results of these audits will be reported to the QAPI Committee for review and recommendations. These audits will continue until the QAPI Committee has determined that compliance has been achieved.<br><br>The Administrator is responsible for compliance with this requirement.<br><br>Completion Date: 5/2/17 | |

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| F 225 | Continued From page 2<br>if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to immediately report potential abuse/mistreatment and/or neglect to the State agency (SA) for 1 of 3 residents (R64) who sustained fractures from an unwitnessed fall.<br><br>Findings include:<br><br>R64's quarterly Minimum Data Set (MDS) dated 12/20/16 indicated R64 had severe cognitive impairment and diagnoses which included Alzheimer's disease, depression, bipolar disorder, anxiety disorder and psychotic disorder. The MDS also indicated R64 exhibited fluctuating inattention symptoms of delirium and daily wandering behavior. The MDS further indicated R64 required extensive assistance of one staff for bed mobility, transfer, dressing, toilet use, and personal hygiene and required limited assistance of one person for ambulation and locomotion on the unit.<br><br>R64's Fall Assessment dated 3/2/17, indicated on 3/2/17, at 2:05 a.m. R64 had a fall in the bathroom by the TV room. The Assessment indicated R64 had been left alone on the toilet when the nursing assistant (NA) obtained a brief from R64's room. When the NA returned to the TV room bathroom, R64 was found face down on the floor. R64 was sent to the emergency room for an evaluation and was found to have a fractured nose and wrist. The Assessment | F 225 | | |

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| F 225 | Continued From page 3<br>included the question "Does this fall appear to constitute abuse or neglect of a vulnerable adult?" A choice of "No" was circled. The Assessment directed notification of the SA for a "Yes" response. In addition, the Assessment indicated the fall was reviewed by the fall committee on 3/2/17, and report to the SA was not indicated.<br><br>Review of Vulnerable Adult (VA) reports from October 2016, through March 2017, lacked a report for R64's fall with serious injury.<br><br>On 3/22/17, at 1:03 p.m. director of nursing (DON) and registered nurse (RN)-B confirmed R64's fall on 3/2/17, was unwitnessed.<br><br>On 3/23/17, at 3:08 p.m. the administrator and director of nursing (DON) confirmed R64's fall with fractures was not immediately reported to the SA, as required. The DON stated she was not aware a fall with serious injury was required to be reported.<br><br>The Assessment After a Fall policy dated 4/2015, directed all falls would be reviewed by the Fall Committee on a daily basis and reports would be filed to the SA, if indicated.<br><br>The Abuse Prevention/Prohibition Program policy dated 11/20/16, indicated fractures were possible indicators of abuse or neglect that should be promptly reported. The policy also identified an injury should be classified as an injury of | F 225 | | |

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| F 225 | Continued From page 4<br>unknown origin when both the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further directed allegations of abuse, neglect, suspicious injury of unknown origin and misappropriation of resident property would be reported immediately to the SA. | F 225 | | |
| F 226 SS=D | 483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>483.12<br>(b) The facility must develop and implement written policies and procedures that:<br><br>(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,<br><br>(2) Establish policies and procedures to investigate any such allegations, and<br><br>(3) Include training as required at paragraph §483.95,<br><br>483.95<br>(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-<br><br>(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident | F 226 | **F226**<br><br>R64's fall dated 3/2/2017 was reported to the SA on 4/20/2017. The Disposition Letter from MDH was received on 4/26/17 stating that the information has been reviewed and it has been determined that no further action by this office is necessary at this time<br><br>All incidents of potential abuse/mistreatment and/or neglect will be reported to the SA immediately.<br><br>The Abuse Prevention/Prohibition Program was reviewed on 4/20/2017.<br><br>Education will be provided to all charge nursing staff regarding Vulnerable Adult reporting requirements for unwitnessed falls resulting in injury. | |

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| F 226 | Continued From page 5<br>property as set forth at § 483.12.<br><br>(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property<br><br>(c)(3) Dementia management and resident abuse prevention.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to operationalize their abuse policy and procedures related to the immediate reporting of potential abuse/mistreatment or neglect to the State agency (SA) for 1 of 3 residents (R64) reviewed for abuse prohibition who had a fall with serious injury.<br><br>Findings include:<br><br>The Abuse Prevention/Prohibition Program policy dated 11/20/16, Identification section indicated a fracture as a possible indicator of abuse or neglect which should be promptly reported. The Investigation section indicated the facility would evaluate injuries of unknown origin as a possible indicator of abuse, neglect or maltreatment warranting the need for further investigation. Injuries of unknown origin would be classified as an injury of unknown origin when both the source of the injury was not observed by any person or the source of the injury could not be explained by the resident, and the injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further indicated an | F 226 | The Administrator or designee will audit all falls to ensure proper reporting protocols are followed.<br><br>Results of these audits will be reported to the QAPI Committee for review and recommendations. These audits will continue until the QAPI Committee has determined that compliance has been achieved.<br><br>The Administrator is responsible for compliance with this requirement.<br><br>Completion Date: 5/2/17 | |

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| F 226 | Continued From page 6<br>investigation would normally be conducted by the administrator or director of nursing (DON) or designee. Staff were directed to promptly report any incident or suspected incident of resident abuse or neglect including suspicious injuries of unknown origin and to report internally to allow the facility to begin to initiate an investigation, and report allegations immediately to the State agency, as required.<br><br>R64's quarterly Minimum Data Set (MDS) dated 12/20/16, indicated R64 had severe cognitive impairment and diagnoses which included Alzheimer's disease, depression, bipolar disorder, anxiety disorder and psychotic disorder. The MDS also indicated R64 exhibited fluctuating inattention symptoms of delirium and daily wandering behavior. The MDS further indicated R64 required extensive assistance of one person for bed mobility, transfer, dressing, toilet use, and personal hygiene and required limited assistance of one person for ambulation and locomotion on the unit.<br><br>R64's Fall Assessment dated 3/2/17, indicated R64 had a fall in the bathroom by the TV room at 2:05 a.m. on 3/2/17. The Assessment indicated R64 had been left alone on the toilet when the nursing assistant (NA) obtained a brief from R64's room. When the NA returned to the TV room bathroom, R64 was found face down on the floor. The assessment also indicated the fall resulted in an emergency room visit where R64 was found to have a fractured nose and wrist. The Assessment included the question "Does this fall appear to constitute abuse or neglect of a | F 226 | | |

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| F 226 | Continued From page 7<br>vulnerable adult?" A choice of "No" was circled. The Assessment directed notification of the SA for a "Yes" response. In addition, the Assessment indicated the fall was reviewed by the fall committee on 3/2/17, and report to the SA was not indicated.<br><br>Review of Vulnerable Adult (VA) reports from October 2016 through March 2017 lacked a report for R64's fall with serious injury.<br><br>On 3/22/17, at 1:03 p.m. the DON and registered nurse (RN)-B confirmed R64's fall on 3/2/17, was unwitnessed.<br><br>On 3/23/17, at 3:08 p.m. the administrator and DON confirmed R64's fall with fractures was not immediately reported to the SA as required. The DON stated she was not aware a fall with serious injury was required to be reported. | F 226 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans | F 279 | **F 279**<br><br>Resident 88's care plan did not identify risk/goals for pressure ulcers and did not include a goal and non-pharmacological interventions for hypnotic medications.<br><br>Resident 69's care plan did not include goals or medical management interventions for a cardiac pacemaker. | |

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| F 279 | Continued From page 8<br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to | F 279 | On 3/22/17, resident 88's care plan was updated to identify the presence, goal, and approaches related to two stage two pressure ulcers. Resident 88's pressure ulcers were healed on 4/18/17 so his/her care plan now identifies his/her risk/goals for pressure ulcers. On 3/24/17 resident 88's care plan was updated to reflect his/her diagnosis of insomnia. A goal and non-pharmacological interventions related to the prescribed hypnotic medication were included on his/her care plan. A new tissue tolerance test was completed on resident 88 on 4/20/17.<br><br>On 3/22/17, resident 69's care plan was updated to include goals and medical management interventions for his/her cardiac pacemaker.<br><br>All residents care plans will be reviewed and revised prior to 5/2/17 for the risk of pressure ulcer development, non-pharmacological interventions for hypnotics, as well as cardiac pacemaker medical management.<br><br>Education will be provided to all charge nurses regarding care plan development prior to 5/2/17.<br><br>The facility's policy on nursing care plans was revised on 4/17/17. | |

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| F 279 | Continued From page 9<br>local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to develop a care plan related to the identified risk/goals for pressure ulcers in order to prevent the risk for the development for pressure ulcers and failed to develop a care plan which included a goal and non-pharmacological interventions to be implemented for 1 of 4 residents (R88) reviewed for pressure ulcers and hypnotic medication use. In addition, based on observation, interview, and document review the facility failed develop a care plan for a cardiac pacemaker which included goals and medical management interventions for 1 of 1 resident (R69) reviewed who had a pacemaker.<br><br>Finding included:<br><br>R88 was at risk for pressure related ulcers and received medication to induce sleep for a diagnosed sleep disorder and a care plan was not developed to identify these areas.<br><br>R88's undated Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, obstructive sleep apnea, myelodysplastic syndrome (a blood | F 279 | Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are revised appropriately. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for compliance with this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 279 | Continued From page 10<br>cancer), and anxiety disorder.<br><br>R88's admission Minimum Data Set (MDS) dated 12/18/16, indicated R88 had severe cognitive impairment, required extensive assistance from one to two staff for activities of daily living, had balance impairment and had functional limitations in range of motion in one upper extremity. The MDS further indicated R69 was frequently incontinent of urine, did not have a pressure ulcer upon admission, was at risk for pressure ulcers, and had a turning and repositioning program. The 14 day Medicare MDS dated 12/25/16, indicated R69 had trouble falling asleep, staying asleep, or sleeping too much.<br><br>Physician's orders included, Trazodone 50 milligrams by mouth at bedtime, and may give one additional dose as needed after the scheduled bedtime dose prior to 3:00 a.m.<br><br>R88's pressure ulcer CAA dated 12/18/16 indicated R88 was at risk for pressure ulcers related to urinary incontinence, and impaired mobility that required extensive assistance from staff, cognitive loss, functional limitation in range of motion, diagnosis of dementia, pain, weakness, fracture of clavicle, and poor nutrition. The CAA indicated R69 required a regular schedule of turning and staff would turn and reposition every two hours while in bed. The CAA indicated a care plan would be developed and R88 would have intact skin and continue to reposition as scheduled. | F 279 | | |

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| F 279 | Continued From page 11<br>R88's current care plan dated 12/28/16, did not identify R88 was at risk for pressure ulcers and lacked a goal for preventing or decreasing the risk of obtaining a pressure ulcer. The care plan indicated R88 had alteration in elimination and was incontinent more than seven times per week and directed staff to provide extensive assist of two staff to transfer on and off toilet every two hours, staff check with toileting and change as needed, and provide peri rectal care after elimination. The care plan also indicated R88 had decreased physical mobility with potential for falls and directed staff to provide extensive assist of one to turn and reposition every two hours. The care plan identified R88 was at risk for dehydration and directed staff to monitor skin for hydration, redness, and breakdown. The care plan lacked a care plan for sleep which would include goals, medication management of Trazodone (medication to induce sleep) and non-pharmacological interventions to be attempted prior to the administration of the Trazadone.<br><br>On 3/23/17, at 2:43 p.m. registered nurse (RN)-E confirmed a specific care plan was not developed nor was an assessed goal identified for pressure ulcers, however, stated the interventions to reduce the risk for pressure ulcers were added to the problem statement that was causing the risk. RN-E stated a specific care plan for pressure ulcers would be developed if there was an actual pressure ulcer or history of pressure ulcers.<br><br>-At 4:27 p.m. the director of nursing (DON) confirmed there should have been a care plan developed for pressure ulcers and for sleep. | F 279 | | |

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| F 279 | Continued From page 12<br>R69 had a pacemaker which was not identified on the care plan.<br><br>R69's admission MDS dated 1/20/17 included diagnoses of atrial fibrillation, heart failure, hypertension, and history of stroke. The MDS indicated R69 had moderate cognitive impairment and required extensive assistance from staff to complete activities of daily living. R69's undated Face Sheet indicated R69 had a diagnosis of old myocardial infarction (heart attack). R69's hospital Discharge Summary dated 1/20/17, indicated R69 had a pacemaker.<br><br>R69's care plan dated 2/8/17 identified diagnosis of atrial fibrillation and stroke, however did not identify the presence of R69's pacemaker.<br><br>On 3/20/17, at 7:22 p.m. a pacemaker monitor was observed on R69's nightstand. R69 explained the purpose of the monitor was so the pacemaker clinic could continuously monitor the functionality of the pacemaker and monitor for abnormal heart rhythms. R69 stated he was supposed to have his pacemaker checked every three months.<br><br>On 3/22/17, at 7:09 a.m. licensed practical nurse (LPN)-D stated was not sure where to find information pertaining to R69's pacemaker, was not sure what arrhythmia the pacemaker was set to correct, and did not know R69's pulse parameters. LPN-D stated the registered nurses (RN) obtained information pertaining to pacemakers and would develop the care plan. | F 279 | | |

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| F 279 | Continued From page 13<br>-At 10:51 a.m., pacemaker clinic registered nurse (RN)-F indicated R69's pacemaker was for bradycardia (slow heart rate), was not a defibrillator, the low end setting was 70 beats per minute, RN-F explained if R69's pulse should go under 70 beats for a full minute, it was a concern, and the staff at the facility would need to call the pacemaker clinic to ensure pacer was functioning appropriately. RN-F stated the pacemaker clinic expected facility staff to have knowledge of pacemaker settings, when to contact the clinic, and of recommended pacemaker checks.<br><br>-At 11:00 a.m., the DON indicated there should have been a care plan developed for the pacemaker.<br><br>-At 12:27 p.m., RN-E stated she did not know why R69 had a pacemaker and thought the care plan included the pacemaker, and was not aware if the pacemaker should have been on the care plan.<br><br>Facility policy Resident Care Planning last reviewed 4/2015 included: Planning Objectives and Rationale 1. to promote optimal resident independence and quality of care by focusing and directing staff efforts to individuals, 2. To promote appropriate utilization and coordination of services and avoid duplication and wasted efforts, 7. To meet accountability requirements for fiscal intermediaries. The policy lacked direction and/or requirements for the care plan content. | F 279 | | |
| F 280 SS=D | 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10 | F 280 | **F 280**<br><br>On 4/26/17 resident 64's care plan was reviewed and revised to include new fall interventions. | |

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| F 280 | Continued From page 14<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(i) Facilitate the inclusion of the resident and/or resident representative.<br><br>(ii) Include an assessment of the resident's strengths and needs.<br><br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21 | F 280 | On 4/17/17, resident 88's care plan was reviewed and revised to include non-pharmacological interventions for pain management.<br><br>All resident's care plans will be reviewed and revised prior to 5/2/17 regarding fall interventions as well as non-pharmacological interventions for pain management.<br><br>Education will be provided to all charge nurses regarding care plan revision prior to 5/2/17.<br><br>The facility's policy on nursing care plans was revised on 4/17/17.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are revised appropriately. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for compliance with this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 280 | Continued From page 15<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the | F 280 | | |

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| F 280 | Continued From page 16<br>facility failed to revise the care plan to include additional fall prevention interventions following fall incidents for 1 of 4 residents (R64) reviewed for accidents. In addition, the facility failed to revise the care plan for pain to include non-pharmacological interventions for 1 of 5 residents (R88) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R64's care plan was not revised to include additional fall prevention interventions following fall incidents.<br><br>R64's Face Sheet [undated], indicated R64's diagnoses included Alzheimer's disease, anxiety, dizziness, seizures, depression, obesity, macular degeneration (poor vision) , cataracts, psychosis, delusional disorder and dementia.<br><br>R64's Fall Risk Assessment dated 2/23/17, indicated R64 was at risk for falls. No new fall prevention interventions were identified and staff were directed to continue with the current fall interventions.<br><br>R64 sustained 12 falls between 10/23/16, through 2/9/17. R64's care plan dated 3/16/17, identified a problem area for potential risk for falls and skin integrity. Fall prevention interventions listed included:<br>- provide assist of one staff to ambulate on and off the unit | F 280 | | |

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| F 280 | Continued From page 17<br>- provide limited assist of one staff to transfer, also transfers self at times<br>- manual tilt and space wheelchair for comfort, positioning and safety<br>- refer to nursing orders for further fall interventions<br><br>R64's physician orders indicated from 10/23/16, through 2/9/17, the following fall prevention interventions were in place which were not identified on the care plan:<br>- Lavender oil behind the ears for relaxation twice a day (initiated 11/23/15)<br>- Contour mattress with cut out (initiated 12/28/15)<br>- 30 minute checks (initiated 2/19/16)<br><br>On 3/23/17, at 2:15 p.m. the director of nursing (DON) confirmed prior to R64's fall on 3/2/17, the only fall prevention interventions documented on R64's physician orders or R64's care plan were lavender oil behind the ears for relaxation twice a day (initiated 11/23/15); contour mattress with cut out (initiated 12/28/15); and 30 minute checks (initiated 2/19/16).<br><br>Fall Prevention policy dated 4/2015, indicated the facility would identify residents who were at high risk for falls and develop individual fall precautions for those residents. A post fall assessment would be completed after each fall and any changes in interventions would be noted on the form, in the residents nursing orders, alarms would be added to the care plan, and staff assignment sheets. | F 280 | | |

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| F 280 | Continued From page 18<br><br>R88's care plan was not revised to include non-pharmacological interventions for pain control which could be attempted prior to administration of an as needed pain medication.<br><br>R88's Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, myelodysplastic syndrome, diverticulitis, and anxiety disorder.<br><br>R88's admission Minimum Data Set (MDS) dated 12/18/16, indicated R88 had severe cognitive impairment, had occasional pain which did not interfere with activities or sleep, had scheduled pain medications, rated pain at a 5 on a 0-10 scale, used as needed pain medications, and non-pharmacological interventions were not used. A Care Area Assessment for pain was not triggered or completed.<br><br>R88's care plan for pain dated 12/28/16, indicated R88 had a potential for alteration in comfort related to a cervical spine fracture, left clavicle fracture and low back pain. The care plan directed staff to medicate as ordered, use a pain scale to assess pain, assist to positron for comfort and to keep physician updated. The care plan lacked non pharmacological interventions to be attempted prior to the use of pain medication.<br><br>R88's physician orders revealed an order for Neurontin solution 250mg/5ml (milliliters) give 50 mg every two hours as needed for pain, anxiety, | F 280 | | |

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| F 280 | Continued From page 19<br>restlessness. Max of six as needed doses in 24 hours.<br><br>On 03/23/2017, at 4:27 p.m. director of nursing (DON) indicated the care plan should include non-pharmacological interventions that could attempted prior to administration of an as needed pain medication.<br><br>Facility policy Resident Care Planning Policy and Procedure last reviewed 4/2015, indicated care plans were to be reviewed every 30 days by an RN. If changes in a problem, goal, or approach occurred between scheduled review times the charge nurse and department member involved in the revision must meet informally and revise the care plan. | F 280 | | |
| F 282 SS=D | 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br><br>(ii) Be provided by qualified persons in accordance with each resident's written plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide turning and repositioning assistance and/or incontinence cares as directed by the care plan 2 of 2 residents (R15, R89) who required assist with repositioning and incontinence cares. In addition, | F 282 | **F 282**<br><br>Resident 15 is receiving repositioning and toileting per his care plan. Resident 89 is receiving repositioning per her care plan and is wearing her Prevalon boots per orders.<br><br>All NA's were educated and made aware of resident 15's care plan regarding repositioning and toileting. All NAs were educated regarding resident 89's care plan for repositioning and Prevalon boot placement. | |

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| F 282 | Continued From page 20<br>the facility failed to ensure the placement of Prevalon pressure reduction boots as directed by the care plan for 1 of 2 (R89) residents at risk for heel breakdown.<br><br>Findings include:<br><br>R15 was at risk for pressure ulcers and was incontinent and did not receive timely turning and repositioning and incontinence care as directed by the care plan.<br><br>R15's Care Plan dated 1/18/17, indicated R15 had decreased physical mobility, bilateral lower extremity amputation with inability to transfer, turn/reposition or site up/lie down per self. R15 required two staff extensive assist for turning and repositioning every hour. R15 was unable to complete personal hygiene independently and had bowel and bladder incontinence. The plan indicated R15 required extensive assistance of two staff to check and change R15's incontinent product and provide cleansing after elimination every two hours.<br><br>The untitled and undated nursing assistant worksheets indicated R15 required turning and repositioning assistance every hour and toileting/incontinent checks every two hours.<br><br>On 3/22/17, during continuous observations from 7:15 a.m. to 11:00 a.m. R15 was observed to remain seated in her wheelchair without receiving assistance. | F 282 | All residents care plans will be reviewed and updated for repositioning and toileting if indicated prior to 5/2/17.<br><br>Education will be provided to all NA's prior to 5/2/17 to stress the importance of following care plans for toileting, repositioning, and Prevalon boot placement.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for compliance with this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 282 | Continued From page 21<br>-At 7:45 a.m. R15 was observed to propel her wheelchair to the dining room for breakfast and returned to her room.<br>-At 9:04 a.m. licensed practical nurse (LPN)-A entered R15's room to administer medication. LPN-A did not offer nor provide R15 repositioning or toileting assistance.<br>-At 9:53 a.m. R15's call light was observed on.<br>-At 9:58 a.m. nursing assistant (NA)-C was entered R15's room, turned the call light off and immediately exited the room.<br>-At 10:00 a.m. R15 stated she had told the NA she needed her incontinent product changed and the NA stated she would be back to help her because she was busy with another resident.<br>-At 10:18 a.m. NA-C returned to R15's room and proceeded to assist R15's roommate.<br>-At 10:35 a.m. NA-C began to assist R15. R15 asked her what she was doing and NA-C informed R15 she was going lay her down. R15 stated she did not want to lie down. NA-C stopped assisting R15 and stated R15 refused a lot. When asked by the surveyor if she would lay down so staff could change her incontinent product, R15 stated that was why I turned the call light on in the first place.<br>-At 10:45 a.m. NA-C proceeded to provide R15 incontinent cares. When removed, the incontinent product was observed to be extremely saturated with urine. NA-C confirmed the brief was saturated. NA-C proceeded to cleanse R15's peri area with wipes. R15 asked NA-C stated are you doing, NA-C stated she needed to cleanse R15 well due to R15's peri area scratches. Upon completing the peri care, NA-C stated she needed to get the nurse and would be right back. NA-C returned to the room with LPN-A who applied a tegaderm dressing to R15's right buttock covering an open area. LPN-A informed | F 282 | | |

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| F 282 | Continued From page 22<br>R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 centimeters (CM) by 0.50 cm. LPN-A stated R15 frequently scratched her body including her peri area resulting in open areas and scratch marks. LPN-A stated she applied the dressing to help prevent infections. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently falls off.<br>-At 10:58 a.m. R15's cares were completed. NA-C confirmed R15's brief was very saturated with urine and her skin was wet. NA-C stated she had not provided R15 with turning and repositioning and incontinence cares until just now.<br>-At 10:59 a.m. NA-B entered R15's room. NA-B stated she had assisted R15 up at 7:00 a.m. and pointed to a white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B verified 7:00 a.m. was noted on the board. NA-B confirmed she had not provided incontinence care or repositioning assistance to R15 since 7:00 a.m. (three hours and 30 minutes earlier). NA-B referred to the nursing assistant work sheet which she removed from her pocket and verified R15 was to be repositioned every hour and incontinent product checked and changed every two hours. NA-B stated even though R15 could tell us she needed help, it was staff's responsibility to provide the cares without R15 having to ask us.<br><br>On 3/22/17, at 11:10 a.m. the director of nursing (DON) confirmed R15 should have been repositioned every hour and provided with check and change incontinence care every two hours as directed by the care plan. The DON stated it was | F 282 | | |

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| F 282 | Continued From page 23<br>her expectation for staff to follow and implement R15's care plan, as written.<br><br>R89 was not provided every one hour repositioning during two observations and Prevalon boots (heel offloading device/boots) were not provided for 1 hour 30 minutes on 3/22/17, as directed by the Care Plan<br><br>R89's undated Care Plan indicated R89 had potential for alteration in skin integrity related to pressure sore on left heel and directed staff to:<br><br>--turn and reposition every one hour and as needed<br>--provide peri rectal care after each incontinent episode.<br>--monitor for persistent red areas and report to registered nurse (RN)<br>--maintain adequate nutrition and hydration by providing dietary decub [decubitus] program<br>--wound care/dressing change as ordered.<br>--keep skin clean and dry.<br>--APP [alternating pressure pad] mattress on bed.<br>--pressure relief boots on both feet as ordered.<br><br>R89's Physician Order Report dated 2/23/17-3/23/17, included an order to wear Prevalon (blue) heel lift boots at all times except for bathing. Ensure heel is in proper position.<br><br>On 3/22/17, from 7:03 a.m. until 8:28 a.m. (1 hour 25 minutes) R89 was continuously observed sleeping bed, lying on her back with her shoulders positioned slightly to the right. R89 | F 282 | | |

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| F 282 | Continued From page 24<br>was not repositioned or offered repositioning during this time.<br><br>-From 9:16 a.m. to 10:47 a.m. R89 was continuously observed in bed, lying on her back without staff entering her room for repositioning.<br><br>--at 10:47 a.m. R89 was observed awake and watching television while in bed, positioned on her back. R89 stated she liked to sleep in in the morning and no one had come in to get her up for the day yet.<br><br>--at 10:52 a.m. licensed practical nurse (LPN)-A entered R89's room with a syringe and administered R89's insulin in the abdomen. R89 remained positioned on her back. LPN-A did not offer or provide repositioning assistance.<br><br>--at 11:26 a.m. (2 hours and 10 minutes later) NA-C stated she had last been in R89's room at 9:15 a.m. at which time she checked R89's incontinence brief and asked R89 if she wanted to get up for the day. NA-C indicated R89's brief had been dry and R89 was not ready to get up. NA-C entered R89's room, gathered a basin of water and proceeded to provide morning cares. When, NA-C uncovered R89, she was observed wearing blue Prevalon boots on both feet. NA-C removed the boots which revealed gauze dressing on the left heel. R89's right heel was intact and without redness. Following the completion of personal cares, NA-C stated R89 was to be repositioned every two hours. NA-C stated it used to be every hour when R89 had an open sore to her heel. NA-C assisted R89 to complete dressing and placed a mechanical lift sling under R89. NA-A entered the room with a mechanical lift and both NAs transferred R89 to | F 282 | | |

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| F 282 | Continued From page 25<br>the wheelchair. R89's wheelchair was observed equipped with a seat cushion and a padded board positioned across the calf support area of the wheelchair foot/leg rests. The foot/leg rests were raised slightly less than parallel to the floor. NA-C wheeled R89 out of her room and to the dining room at approximately 12:00 p.m. R89's Prevalon boots were not reapplied.<br><br>On 3/22/2017, at 1:37 p.m. R89 was observed in her room, seated in her wheelchair. LPN-A stated she had just assisted R89 to put on her Prevalon boots. LPN-A verified R89 had not had them on and confirmed she should have them on at all times due to issues with her heels. NA-C asked LPN-A, "Aren't we supposed to release them once in a while?" LPN-A stated the boots should be on at all times.<br><br>On 3/22/17 at 1:40 p.m. NA-C confirmed she had not put R89's Prevalon boots on when she got R89 up for the day and should have done so. NA-C verified the boots were off for approximately one hour and 30 minutes.<br><br>On 3/23/2017, at 9:51 a.m. RN-A confirmed R89 should have been turned and repositioned every one hour and should have worn the Prevalon boots at all times except for bathing, as directed by the care plan.<br><br>A Resident Care Planning Policy and Procedure, reviewed 4/2015, indicated the care plan was to promote optimal resident independence and | F 282 | | |

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| F 282 | Continued From page 26<br>quality of care by focusing and directing staff efforts to individual needs and to promote appropriated utilization and coordination of services. | F 282 | | |
| F 309 SS=D | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.<br><br>483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:<br><br>(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards | F 309 | **F 309**<br><br>Resident 69's care plan was updated to include goals and medical management interventions for the cardiac pacemaker.<br><br>All residents care plans will be reviewed and revised prior to 5/2/17 for the management of cardiac pacemakers.<br><br>Education will be provided to all Registered Nurses regarding care plan development prior to 5/2/17.<br><br>The facility's policy on nursing care plans was revised on 4/17/17.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are revised when indicated. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for compliance with this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 309 | Continued From page 27<br>of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide ongoing monitoring and coordination of care with a pacemaker clinic to ensure routine pacemaker checks were completed for 1 of 1 resident (R69) reviewed who a had pacemaker without routine checks had conducted.<br><br>Findings included:<br><br>R69's admission Minimum Data Set (MDS) dated 1/20/17, indicated R69 had diagnoses of atrial fibrillation (irregular heart rhythm, often time's rapid heart rate), heart failure, hypertension, and history of stroke. The MDS also indicated R69 had moderate cognitive impairment and required extensive assistance from staff to complete activities of daily living. R69's undated facility Face Sheet also included diagnosis of old myocardial infarction (heart attack). R69's hospital Discharge Summary dated 1/20/17, indicated R69 had a pacemaker.<br><br>R69's Clinical Admission Assessment dated 1/21/17, indicated R69 had a pacemaker and was due for a pacer check sometime this month [January 2017] and while at home, R69 performed these checks wirelessly. The assessment did not include or identify the indication for pacemaker and/or type, pacemaker rate settings, pulse parameters, location, or | F 309 | | |

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| F 309 | Continued From page 28<br>pacemaker check schedule.<br><br>R69's care plan dated 2/8/17, indicated R69 had diagnoses of atrial fibrillation and stroke, however the plan did not identify the presence of R69's pacemaker.<br><br>R69's Vitals Report was reviewed since admission and revealed R69's pulse was taken on taken on 1/20, 1/21 (4 times), 1/29, 2/1, 3/1, 3/8, and on 3/15/17. The record reflected on 1/20/17, R69's pulse was 68. However, R69's medical record lacked evidence the pacemaker clinic was notified of R69's pulse below the low end setting of 70 beats per minutes as indicated by the pacemaker clinic registered nurse (RN)-F.<br><br>On 3/20/17, at 7:22 p.m. a pacemaker monitor was observed on R69's nightstand. R69 stated the purpose of the monitor was so the pacemaker clinic could continuously monitor the functionality of the pacemaker and to monitor for abnormal heart rhythms. However, R69 stated the monitor had not worked since admission to the facility and was not sure when it was going to get fixed. R69 stated he was supposed to have his pacemaker checked every three months and thought he had missed the last scheduled check.<br><br>On 3/22/17, at 7:09 a.m. licensed practical nurse (LPN)-D stated was not sure where to find information pertaining to R69's pacemaker and was not sure what arrhythmia the pacemaker was set to correct, and did not know R69's pulse parameters. LPN-D stated the registered nurses | F 309 | | |

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| F 309 | Continued From page 29<br>(RN) obtained information pertaining to pacemakers and would develop the care plan.<br><br>-At 8:47 a.m. RN-C stated she was aware R69 had a pacemaker, however, was not aware of what arrhythmia the pacemaker was supposed to correct and if there were recommended pulse parameters. RN-C confirmed R69's pacemaker was supposed to be checked sometime in January, however the facility could not get the monitor hooked up due to the lack of correct adapters and the lack of manufacturer's directions which the resident had left at home. RN-C stated when all of the equipment was obtained the pacemaker clinic was called to assist with set-up and to ensure functionality. RN-C stated the pacemaker was checked on 2/27/17, but was not aware of when the next check was to be conducted, however stated it should be every three months.<br><br>-At 10:51 a.m. RN-F stated R69's pacemaker was for bradycardia (slow heart rate), was not a defibrillator and the low end setting was 70 beats per minute. RN-F confirmed R69's last pacemaker check was 10/17/16, and had missed a scheduled check. RN-F stated it would be a concern if R69's pulse should go under 70 beats for a full minute and facility staff would need to call the pacemaker clinic to ensure the pacemaker was functioning properly. RN-F stated if the pacemaker monitor was off line, the pacemaker itself would continue to store information of irregular rhythms until the next pacemaker check. RN-F stated the pacemaker clinic expected the staff to have knowledge of pacemaker settings, when to contact the clinic, and of recommended pacemaker checks. | F 309 | | |

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| F 309 | Continued From page 30<br>-At 11:00 a.m. the director of nursing (DON) stated there should have been a care plan developed for R69's pacemaker.<br><br>-At 12:27 p.m., RN-E stated she did not know why R69 had a pacemaker, thought the care plan included the pacemaker but was not aware if the pacemaker should be on the care plan or not.<br><br>Facility policy/procedure was requested related to pacemaker care and monitoring and was not received. | F 309 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely bladder incontinence care as directed by the care plan for 1 of 1 resident (R15) who was incontinent of urine and was not provided timely assistance.<br><br>Findings include:<br><br>R15's quarterly Minimum Data Set (MDS) dated 1/16/17, indicated R15 was cognitively intact and required extensive assistance with transfers and toileting. The MDS further indicated R15 was always incontinent, was at risk for the development of pressure ulcers, had moisture | F 312 | **F 312**<br><br>Resident 15 is receiving incontinent care per his/her care plan.<br><br>The facility's policy regarding perineal care was reviewed and revised on 4/21/17.<br><br>All residents care plans will be reviewed and revised if indicated prior to 5/2/17 regarding incontinence care.<br><br>Staff education will be provided to all NA's prior to 5/2/17 to stress the importance of following care plans in regards to timely incontinence care.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure residents are receiving incontinent care per their care plan. | |

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| F 312 | Continued From page 31<br>associated skin damage and required application of topical ointments.<br><br>R15's Urinary incontinence Care Area Assessment (CAA) dated 10/23/15, indicated R15 had stress incontinence which occurred with coughing and sneezing, overflow incontinence due to blocked urethra or weak bladder muscles and functional incontinence due to inability to get to the toilet in time due to physical disability. R15's CAA further indicated R15 was always incontinent of urine, required extensive assist with toileting and was at risk for infection, skin rashes/breakdown, and offensive body odor.<br><br>R15's Care Plan dated 1/18/17, indicated R15 was unable to complete personal hygiene independently, had bowel and bladder incontinence and required two staff extensive assist for toileting needs. The plan directed two staff to check and change R15's incontinent product/brief and provide peri-rectal care every two hours.<br><br>R15's Physician Order Report dated 2/22/17-3/22/17, directed staff to attempt to change brief as soon as it was wet.<br><br>The untitled and undated nursing assistant worksheets, indicated R15 required toileting checks every two hours.<br><br>On 3/22/17, during continuous observations from 7:15 a.m. to 11:00 a.m. (3 hours and 45 minutes) R15 was observed to remain seated in her | F 312 | The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for compliance with this regulation.<br><br>Completion date: 5/2/17 | |

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| F 312 | Continued From page 32<br>wheelchair without incontinence cares provided.<br><br>-At 7:45 a.m. R15 was observed to propel her wheelchair to the dining room for breakfast and returned to her room.<br><br>-At 9:04 a.m. licensed practical nurse (LPN)-A entered R15's room to administer medication and exited the room. LPN-A did not offer repositioning or toileting assistance to R15.<br><br>-At 9:53 a.m. R15's call light was observed on.<br><br>-At 9:58 a.m. nursing assistant (NA)-C was entered R15's room, turned off the call light and immediately exited the room.<br><br>-At 10:00 a.m. R15 stated, she had told NA-C she needed her incontinent product changed. R15 stated NA-C told her she would be back to help because she was busy with another resident.<br><br>-At 10:18 a.m. NA-C returned to R15's room and proceeded to assist R15's roommate.<br><br>-At 10:35 a.m. NA-C began to assist R15. R15 asked NA-C what she was doing and NA-C responded by informed R15 she was going to lay her down. R15 stated she did not want to lay down so NA-C stopped assisting R15. NA-C stated R15 refused cares a lot. When asked by surveyor if she would lay down so her incontinent product could be changed, R15 stated that was why she had turned the light on in the first place.<br><br>-At 10:45 a.m. NA-C proceeded to remove R15's incontinent brief. The brief was noted to be heavily saturated with urine. NA-C confirmed the brief was saturated and proceeded to cleanse | F 312 | | |

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| F 312 | Continued From page 33<br>R15's peri area with cleansing wipes. When cleansing, R15 asked NA-C what she was doing and NA-C responded by stating she needed to clean her well because of R15's scratch marks on her bottom. Upon completing the peri-rectal cares, NA-C retrieved LPN-A. LPN-A applied a Tegaderm dressing to R15's right buttock and informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 centimeters (CM) by 0.50 cm. and stated R15 frequently scratched her body and perineal area resulting in open areas and scratch marks. LPN-A stated she applied the Tegaderm to help prevent infection. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently fell off.<br><br>-At 10:58 NA-C confirmed R15's incontinent product was heavily saturated and her skin was wet. NA-C verified she had not provided R15 with incontinent cares prior now.<br><br>-At 10:59 a.m. NA-B entered R15's room. NA-B stated she had assisted R15 up at 7:00 a.m. and pointed to the white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B verified 7:00 a.m. was noted on the board. NA-B confirmed she had not provided incontinent cares to R15 since she 7:00 a.m. NA-B also referenced the nursing assistant work sheet and confirmed R15 was to have her incontinent product checked and changed every two hours. NA-B also stated even though R15 could tell us she needed help, it was staff's responsibility to provide the cares without R15 having to ask us.<br><br>On 3/22/17, at 11:10 a.m. the director of nursing | F 312 | | |

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| HAVENWOOD CARE CENTER | 1633 DELTON AVENUE BEMIDJI, MN 56601 |

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| F 312 | Continued From page 34<br>(DON) confirmed R15 should have been provided with incontinence care every two hours, as directed by the care plan. The DON stated it was her expectation for staff to follow and implement R15's care plan, as directed.<br><br>A Resident Care Planning Policy and Procedure, reviewed 4/2015, indicated the care plan was to promote optimal resident independence and quality of care by focusing and directing staff efforts to individual needs and to promote appropriated utilization and coordination of services.<br><br>Although requested, no policy related to incontinence care was provided. | F 312 | | |
| F 314 SS=D | 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. | F 314 | **F 314**<br><br>Resident 88's care plan has been reviewed and revised to include his/her risk of pressure ulcer development. Resident 88's skin was assessed on 4/11/17 and it was noted that one of the stage two pressure ulcers was healed and the other pressure ulcer was scabbed. On 4/18/17 the resident's skin was assessed again and it was observed that the other stage two pressure ulcer was healed as well.<br><br>Resident 89 and resident 15 have been receiving turning and repositioning per their care plan.<br><br>All residents care plans will be reviewed and revised prior to | |

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| F 314 | Continued From page 35<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to prevent the development of two stage 2 pressure ulcers for 1 of 4 residents (R88) who developed two pressure ulcers following admission to the facility. In addition, the facility failed to provide timely repositioning in order to minimize the risk of pressure ulcer development for 2 of 4 residents (R89, R15) identified at risk for pressure ulcers and who required assistance for repositioning.<br><br>Findings included:<br><br>R88's undated Face Sheet included diagnoses of dementia, fracture of left clavicle and seventh vertebra, myelodysplastic syndrome, and anxiety disorder.<br><br>R88's admission Minimum Data Set (MDS) dated 12/18/16, indicated R88 had severe cognitive impairment, required extensive assistance from two staff for bed mobility and toileting, and required extensive assist from one staff for transferring. The MDS further indicated R88 was frequently incontinent of urine, did not have a pressure ulcer upon admission, was at risk for pressure ulcers and was on a turning and repositioning program.<br><br>R88's Pressure Ulcer Care Area Assessment (CAA) dated 12/18/16, indicated R88 was at risk for pressure ulcers related to urinary incontinence, impaired mobility, cognitive loss, | F 314 | 5/2/17 for turning and repositioning.<br><br>The facility's policy on nursing care plans was revised on 4/17/17.<br><br>Education has been provided to all NAs regarding the importance of applying Prevalon boots per the wearing schedule described on the resident's care sheet. The NAs have also been educated on the importance of following resident's care plan regarding turning and repositioning.<br>The facility has implemented weekly skin inspections by a licensed nurse on the residents shower/bath day.<br><br>The LPNs/RNs will be educated on the weekly skin inspections prior to 5/2/17.<br><br>Random turning and repositioning audits as well as care planning audits will be completed by the Director of Nursing or designee weekly x 4 weeks. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for compliance with this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 314 | Continued From page 36<br>functional limitation in range of motion and diagnoses of dementia, pain, weakness, fracture of clavicle, and poor nutrition. The CAA indicated R69 required a turning schedule and staff would turn and reposition R88 every two hours while in bed. The CAA indicated R88 received no at risk medications, however failed to identify the use of antidepressant, antipsychotics, and narcotic pain medications that could increase the risk for pressure ulcers. The CAA indicated a care plan would be developed related to the risk for pressure related ulcers.<br><br>R88's Braden scale (tool used to help determine the risk for developing pressure ulcers) dated 3/20/17, indicated R88 was at risk for pressure ulcers.<br><br>R88's Tissue Tolerance Assessment (a tool to determine amount of time skin can tolerate pressure without change) dated 3/20/17, indicated R88 should be repositioned every two hours while in the wheelchair, reclining chair, and bed.<br><br>R88's care plan dated 12/28/16, indicated R88 had decreased physical mobility and directed staff to provide extensive assistance to turn and reposition every two hours, assist to sit up/lie down and get feet and legs into bed. Assist of one to ambulate and transfer. Staff to wheel to all destinations. Monitor for persistent red areas and notify the registered nurse. The care plan did not indicate R88 was at risk for pressure related ulcers. R88 had alteration in elimination, was incontinent and directed staff to provide extensive | F 314 | | |

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| F 314 | Continued From page 37<br>assist of two to toilet every two hours, check with toileting and change as needed, and provide peri rectal care after elimination. The care plan also indicated R88 was at risk for dehydration and directed staff to monitor R88's skin for hydration, redness and breakdown.<br><br>R88's nursing assistant (NA) care guide directed staff to turn and reposition R88 every two hours.<br><br>R88's quarterly dietary assessment dated 3/13/17, indicated R88 had a significant weight loss of 9% in 30 days, and R88 had an approximately 30 day inpatient behavioral health clinic stay and returned to the facility on 2/2/17. The assessment indicated R88 was able to feed himself and on 2/3/17, four ounces of dietary supplement was initiated four times a day. R88's recorded weights revealed an admission weight of 124 lbs. (pounds), weight on 2/6/17, 121 lbs. and on 3/21/17, R88 weighed 116 lbs.<br><br>R88's physician orders included Neurontin (pain medication) three times a day and as needed for pain, anxiety and restlessness. Oxycodone, a narcotic, three times a day for low back pain. Tylenol three times a day for low back pain. Trazodone an antidepressant, 50 mg for trouble sleeping. Effexor, an antidepressant, extended release every evening for anxiety disorder and Seroquel three times a day and as needed for paranoia/agitation.<br><br>R88's progress notes and Medication Administration Records (MAR) were reviewed | F 314 | | |

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| F 314 | Continued From page 38<br>since admission and revealed the following:<br><br>-Progress note dated 2/27 at 2:54 a.m. R88 slept in a recliner in the TV lounge and refused to go to his bed. Progress note entry at 10:16 a.m. indicated R88 had been yelling his back and bottom hurt, medications were given, and he was transferred to another chair with no relief. Documentation does not reflect evidence of a skin assessment which would have included a skin inspection.<br><br>-Progress note dated 2/28/17, at 4:59 p.m. indicated R88 was demonstrating behaviors. R88 was more restless and his bottom hurt. As needed Seroquel and Trazodone were administered. Documentation does not reflect evidence of a skin assessment which would have included a skin inspection.<br><br>-MAR dated 3/3/17, indicated on 3/3/17, at 3:04 p.m. as needed dose of Neurontin was administered for buttocks pain and headache. Documentation indicated the dose was not effective. Corresponding progress note indicated staff had repositioned R88 every two hours and applied barrier cream, however, the note lacked evidence that a skin inspection was conducted.<br><br>- MAR dated 3/5/17, indicated at 4:51 p.m. as needed dose of Neurontin was administered for buttocks pain, anxiety, and agitation. Documentation indicated the dose was effective, however, the medical record lacked evidence of a skin inspection to rule out impaired skin integrity.<br><br>-Progress note dated 3/13/17, at 2:45 a.m. indicated R88 had been sleeping in the recliner for the first portion of the night. At 1:22 p.m. as | F 314 | | |

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| F 314 | Continued From page 39<br>needed dose of Neurontin was administered due to R88 "screaming about butt pain." Documentation indicated dose was effective. However, the medical record lacked evidence that a skin assessment was completed which would have included a skin inspection.<br><br>R88's medical record lacked evidence of routine skin inspections, monitoring, and/or assessment for impaired skin integrity or changes to skin integrity. The medical record revealed no history of open areas to the skin.<br><br>On 3/21/17, at 8:32 a.m. R88 was observed seated in his wheelchair at the dining room table in a slumped position. A pressure reducing seat cushion was noted in the wheelchair. Implementation date of the seat cushion could not be determined.<br><br>-At 8:36 a.m. R88 planted his feet on the floor and adjusted himself in the chair to a more upright position.<br><br>-At 9:19 a.m. R88 was again in a slumped position while seated in the wheelchair. An unidentified staff member assisted R88 to sit upright by moving behind the wheelchair, wrapping her arms underneath R88's arms and lifted/slid R88 to an upright position.<br><br>-At 2:03 p.m. physical therapist (PT)-D and registered nurse (RN)-C were observed to stand and ambulate R88. R88 took small shuffling steps and required continuous verbal cues from PT-D.<br><br>On 3/22/17, at 7:50 a.m. trained medication | F 314 | | |

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| F 314 | Continued From page 40<br>assistant (TMA)-B stated it was time to administer R88's medications which included pain pills. R88 was lying in bed when TMA-B entered the room. TMA-B asked R88 if he had any pain in which R88 had denied.<br><br>-At 7:52 a.m. licensed practical nurse (LPN)-D entered the room with R88's medications. R88 stated "leave me alone", LPN-D explained she had medications and he needed to sit up. When TMA-B and LPN-D attempted to assist R88 to sit on the side of the bed, R88 stated "ouch" a couple of times and cried "just leave me alone." LPN-D informed R88 she had his pain pills and he needed to sit up. When R88 was sitting on the edge of the bed, and as LPN-D attempted to administer medications, R88 stated his bottom hurt. R88 continued to be verbally resistive, however cooperative, and LPN-D stated she would administer the rest of the medications after R88 was up and dressed. LPN-D proceeded to exit the room.<br><br>-At 8:02 a.m. TMA-B donned gloves, directed and assisted R88 to roll over onto his right side. As TMA-B pulled R88's incontinent brief from underneath R88, R88 yelled "ouch, you are hurting me, leave me alone." When TMA-B started to wash R88's bottom, R88 again yelled "ouch." TMA-B stated R88 said ouch quite a bit and continued to wash R88's bottom. Surveyor then requested to inspect R88's skin on his bottom. Inspection revealed a stage two pressure ulcer approximately the size of a pencil eraser on the inside right buttock. The area was slightly raised with an open center. TMA-B indicated she was not aware of the open area and nobody had said anything about R88 having an open area, and R88 did not have any cream in his room to | F 314 | | |

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| F 314 | Continued From page 41<br>put on it either. TMA-B proceeded to complete R88's morning cares.<br><br>-At 8:21 a.m. LPN-D returned to R88's room, both LPN-D and TMA-B completed R88's cares and assisted him to his wheelchair where LPN-D gave R88 the rest of his pills. LPN-D did not observe the open area and no treatment was provided to the pressure ulcer.<br><br>-At 12:02 p.m. RN-C stated the wound had not been previously reported or identified by facility staff and had not been treated. R88's wound was assessed and determined to be a Stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or presented as an intact or ruptured blister) pressure ulcer which measured 0.6 centimeters (cm) by 0.5 cm with a depth of 0.1 cm, and had scant pink drainage, no tunneling and no maceration. RN-C stated a pressure-relieving mattress was put in place, R88's family was contacted, the doctor would be notified, and a consult would be requested from the dietician. RN-C stated nurses did not look at the skin to evaluate or assess except on admission and with change of condition, however, the NAs looked at each residents' skin daily with cares and would report areas of concern to the nurses. RN-C stated NAs also looked at skin on bath days and would document any noted areas of skin concerns on the bath worksheets, give the worksheet to the nurse and the nurse would transcribe any skin condition concern onto a progress note. When asked if staff kept records of skin monitoring or evidence that a skin inspection was conducted following the identification of a skin concern, RN-C stated no, the worksheets were thrown away once | F 314 | | |

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| F 314 | Continued From page 42<br>documented onto the progress note. RN-C stated a resident progress note was only written when there was an area of concern identified. RN-C confirmed R88's medical record lacked evidence of routine skin monitoring and evaluations. RN-C stated when a wound was found, nurses were to complete a wound assessment worksheet and the resident would also be added to the facility's weekly wound rounds.<br><br>-At 1:46 p.m. LPN-D stated R88's scheduled bath day was Friday evenings and confirmed the NAs let the nurses know about any resident skin conditions. LPN-D stated the RNs usually completed a comprehensive skin assessment on admission but nurses did not perform whole body skin inspections and did not know how often, if ever, whole body inspections by a nurse was conducted.<br><br>-At 1:58 p.m. NA-I stated residents' skin was checked daily with cares and on bath days and if she saw something, she would report it to the nurse right away.<br><br>On 3/23/17, at 8:39 a.m. R88 was observed seated in his wheelchair in the lobby area. R88 cried out, "oh God please help me, God please help me I have to go potty, I have to poop!" Surveyor immediately communicated to facility staff R88 had to use the restroom. R88 continued to yell out and became increasingly agitated and fidgety until he was assisted to the bathroom at 8:44 a.m. by NA-H. Once in the bathroom R88 cried out, "Jesus my butt hurts." R88 utilized the grab bar to independently stand up with minimal physical assistance and verbal cues to turn and sit down on the toilet. The Mepilex foam dressing | F 314 | | |

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| F 314 | Continued From page 43<br>dated 3/22/17, was located over the coccyx area and not covering the pressure ulcer on the right inside buttock. NA-H removed the dressing which revealed another stage two pressure ulcer on the coccyx which was slightly smaller than the wound on the right buttock. It was oval shaped with a pink wound bed. NA-H stated she had last worked on Monday and the wound on the coccyx was not there at that time. However, NA-H stated the other wound had always been there. NA-H stated the area would get red, cream would be applied and the next day the area would be gone and in a couple of days the areas would be back again. NA-H confirmed she reported to the nurse when she found skin problems and bath documentation sheets were used to write down any impaired skin integrity. NA-H applied barrier cream to the coccyx wound without obtaining direction from a nurse.<br><br>-At 8:55 a.m. RN-C entered the room. The barrier cream was removed from the coccyx by NA-H. RN-C confirmed the wound had not been previously reported or identified by facility staff and had not been treated. RN-E looked at the wound and stated it was not open, however, wanted another nurse that had better eyes to assess the coccyx wound. A flash light was obtained for better viewing related to poor lighting in the bathroom and once viewed under the flashlight, RN-C confirmed the wound was open and assessed the wound to be a stage two pressure ulcer which measured 0.5 cm by 0.2 cm with a depth of less than 0.1 cm. The area was cleansed and large foam dressing was applied to cover and protect both pressure ulcers. | F 314 | | |

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| F 314 | Continued From page 44<br>-at 9:51 a.m. RN-C stated R88 has had multiple wheelchair changes related to reports of discomfort and confirmed she had observed the skin each time the wheelchair was changed, however had not documented any findings. RN-C stated the skin should be inspected when there were reports of bottom discomfort. The director of nursing (DON) stated she had toileted R88 on Tuesday 3/21/17, and had not noted any impaired skin integrity. The DON stated the NAs looked at residents' skin on a daily basis and also on bath days and reported any concerns to the nurse and the nurses would informally look at the skin when something was brought to their attention. The DON verified the nurses looked at residents' skin and completed the Braden Scale assessment on admission and then weekly for three weeks and then with change of condition.<br><br>-At 1:23 p.m. RN-C indicated interventions implemented included a new mattress, repositioning R88 every hour, cleanse area, apply Mepliex dressing to inner and upper right buttock, change every three days and check position of the dressing every shift and staff to inform the nurse if the dressing was not staying in place. Would also recommend labs to the physician, look into changing seat cushion, lanispetic barrier cream to be applied, request a dietary consult and wounds to be evaluated by the RN weekly and weekly skin checks by the LPN.<br><br>R89 was at risk for pressure ulcers and the staff failed to provide every one hour turning and repositioning and failed to ensure pressure reducing boots were applied at all times, as directed by the care plan. | F 314 | | |

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| F 314 | Continued From page 45<br><br>R89's quarterly MDS dated 1/15/17, indicated R89 had diagnoses which included stage 3 chronic kidney disease, chronic obstructive pulmonary disease, anemia and diabetes. The MDS also indicated R89 was cognitively intact, was non-ambulatory, required extensive assist of two persons for bed mobility and dressing, extensive assist of one person for personal hygiene and was totally dependent on two persons for transfers and toilet use. The MDS further indicated R89 had one unhealed, stage 2 pressure ulcer present on admission to the facility.<br><br>R89's Pressure Ulcer CAA dated 10/27/16, indicated R89 required total assist with bathing and was always incontinent of bowel and bladder. The CAA indicated R89 was at risk for pressure sores, worsening urinary tract infections/sepsis, gangrene, discomfort and weight loss which was complicated by current cellulitis, severe pain, dependence on staff for bed mobility and toileting needs, diabetes and chronic kidney disease.<br><br>R89's undated Care Plan indicated R89 had potential for alteration in skin integrity related to pressure sore on left heel and directed staff to implement the following interventions:<br>--turn and reposition every one hour and as needed<br>--provide perirectal care after each incontinent episode.<br>--monitor for persistent red areas and report to registered nurse (RN)<br>--maintain adequate nutrition and hydration by | F 314 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HAVENWOOD CARE CENTER | 1633 DELTON AVENUE BEMIDJI, MN 56601 |

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| F 314 | Continued From page 46<br>providing dietary decub [decubitus] program<br>--wound care/dressing change as ordered.<br>--keep skin clean and dry.<br>--APP [alternating pressure pad] mattress on bed.<br>--pressure relief boots on both feet as ordered.<br><br>R89's undated Nursing Assistant Care Worksheet directed staff to turn and reposition R89 every one hour and indicated R89 needed to have Prevalon boots (heel offloading device to help prevent the development of heel pressure injuries) on at all times except when bathing.<br><br>R89's Physician Order Report dated 2/23/17-3/23/17, included an order to wear Prevalon (blue) heel lift boots at all times except for bathing. Ensure heel is in proper position.<br><br>R89's Braden Scale dated 2/21/17, indicated R89 was at moderate risk for skin breakdown.<br><br>R89's Tissue Tolerance Assessment dated 10/15/16, directed staff to reposition R89 while in the wheelchair, chair or recliner every one hour and to turn and reposition every one hour when in bed.<br><br>On 3/22/17, from 7:03 a.m. until 8:28 a.m. (1 hour 25 minutes) R89 was continuously observed sleeping in bed, lying on her back under the covers, with her shoulders positioned slightly to the right. R89 was not repositioned or offered repositioning during this time. Unable to determine if R89's Prevalon boots were on, as | F 314 | | |

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| F 314 | Continued From page 47<br>directed.<br>R89 was again continuously observed in bed, lying on her back from 9:16 a.m. to 10:47 a.m. without staff assistance to reposition.<br>--at 10:47 a.m. R89 was observed in bed positioned on her back, awake and watching television. R89 stated she liked to sleep in in the morning and no one had come in to get her up for the day yet.<br>--at 10:52 a.m. LPN-A entered R89's room and administered R89's insulin in the abdomen and immediately exited the room. R89 remained positioned on her back. LPN-A did not offer nor provide repositioning assistance.<br>--at 11:26 a.m. (after 2 hours and 10 minutes) NA-C stated she had last been in R89's room at 9:15 a.m. at which time she checked R89's incontinence brief and asked R89 if she wanted to get up for the day in which R89 declined to get up. R89's brief was dry at that time. NA-C entered R89's room, gathered a bathing supplies and proceeded to assist R89 with morning cares. NA-C uncovered R89 and she was noted to be wearing blue Prevalon boots on both feet. NA-C removed the boots which revealed a gauze dressing to R89's left heel. R89's right heel was intact and without redness. Following perirectal cares, R89 assisted with turning by pulling her shoulders over with the use of a grab bar. However, NA-C was required to assist the turn by pulling a sheet under R89's hips and pushing her hips to lift them off the bed. R89's buttocks were intact with a small pea sized light red area noted to her right buttock. NA-C indicated R89 was to be repositioned every two hours but used to be turned every hour when R89 had an open sore to her heel. NA-A entered the room with a mechanical lift and NA-A and NA-C proceeded to transfer R89 to the wheelchair via the lift. R89's | F 314 | | |

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| F 314 | Continued From page 48<br>wheelchair was equipped with a seat cushion and a padded board was across the calf support area of the wheelchair foot/leg rests. The leg rests were raised. NA-C assisted R89 to complete her morning cares and then wheeled R89 out of her room and to the dining room at approximately 12:00 p.m. R89's Prevalon boots were not reapplied.<br><br>On 3/22/2017, at 1:27 p.m. RN-A stated NA-C had come to her after assisting R89 up for the day and indicated she had thought R89's turning and repositioning schedule was for every two hours. RN-A verified R89's current repositioning schedule was for every one hour.<br><br>On 3/22/2017, at 1:37 p.m. R89 was observed in her room, seated in the wheelchair. LPN-A stated she had just assisted R89 to put on her Prevalon boots. LPN-A verified R89 did not have them on and confirmed she should have them on at all times due to issues with her heels. NA-C asked LPN-A, "Aren't we supposed to release them once in a while?" LPN-A informed NA-C the boots should be on at all times.<br><br>On 3/22/17 at 1:40 p.m. NA-C confirmed she had not put R89's Prevalon boots on when she assisted R89 up for the day and should have done so. NA-C verified the boots were off for approximately one hour and 30 minutes.<br><br>On 3/23/2017, at 9:51 a.m. RN-A verified R89 was admitted to the facility with a left heel ulcer which had recently healed and also had a history | F 314 | | |

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| F 314 | Continued From page 49<br>of pressure ulcers to her bottom. RN-A confirmed R89 should have been turned and repositioned every one hour and should have had the Prevalon boots on at all times except for bathing, as directed on the care plan.<br><br>R15 was at risk for pressure related sores and did not receive timely turning and repositioning assistance as directed by the care plan.<br><br>R15's quarterly MDS dated 1/16/17, indicated R15 had intact cognition and required extensive assistance of two staff for transfers, required extensive assist of two for bed mobility and had no rejection of cares.<br><br>R15's Activity of Daily Living Functional Status, CAA dated 10/23/16, indicated R15 was diagnosed with diabetic neuropathy, chronic obstructive pulmonary disease and bilateral lower extremity amputations. The CAA indicated R15 required extensive assist with repositioning and was at risk for infection, skin rashes/breakdown, and pressure ulcers.<br><br>R15's care plan dated 1/18/17, indicated R15 had decreased physical mobility related to bilateral lower extremity amputation with the inability to transfer, turn, reposition self, to sit up or lie down. Staff were directed to provide extensive assist of two to turn and reposition R15 every hour. The NA worksheets, directed staff to turn and reposition R15 every hour. | F 314 | | |

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| F 314 | Continued From page 50<br>R15's Braden Scale dated 3/20//17, indicated R15 was at risk for pressure ulcers due to inability to bear her own weight and make frequent or significant changes in position.<br><br>On 3/22/17, during continuous observations from 7:15 a.m. to 11:00 a.m. R15 was observed to remain seated in her wheelchair without receiving assistance.<br>-At 7:45 a.m. R15 was observed to propel her wheelchair to the dining room for breakfast and returned to her room.<br>-At 9:04 a.m. LPN-A entered R15's room to administer medication and exited the room. LPN-A did not offer nor provide R15 repositioning assistance.<br>-At 9:53 a.m. R15's call light was observed on.<br>-At 9:58 a.m. NA-C entered R15's room, turned the call light off and immediately exited the room.<br>-At 10:00 a.m. R15 stated she had told the NA-C she needed her incontinent brief changed and the NA stated she would be back to help her because she was busy with another resident.<br>-At 10:18 a.m. NA-C returned to R15's room and proceeded to assist R15's roommate.<br>-At 10:35 a.m. NA-C began to assist R15. R15 asked her what she was doing and NA-C informed R15 she was going lay her down. R15 stated she did not want to lie down. NA-C stopped assisting R15 and stated R15 refused a lot. When asked by the surveyor if she would lay down so staff could change her incontinent brief, R15 stated that was why she had turned the call light on in the first place.<br>-At 10:45 a.m. NA-C proceeded to provide R15 incontinent cares. When removed, the incontinent brief was observed heavily saturated with urine. NA-C confirmed the brief was saturated. NA-C | F 314 | | |

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| F 314 | Continued From page 51<br>proceeded to cleanse R15's peri area with wipes. R15 asked NA-C what are you doing, NA-C stated she needed to cleanse R15 well due to R15's peri area scratches. Upon completing the peri care, NA-C stated she needed to get the nurse and would be right back. NA-C returned to the room with LPN-A who applied a Tegaderm dressing to R15's right buttock covering an open area. LPN-A informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 CM by 0.50 cm. LPN-A stated R15 frequently scratched her body including her peri area resulting in open areas and scratch marks. LPN-A stated she applied the dressing to help prevent infection. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently fell off.<br>-At 10:58 a.m. R15's cares were completed. NA-C confirmed R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had not provided R15 with turning and repositioning and incontinence cares until just now.<br>-At 10:59 a.m. NA-B entered R15's room. NA-B stated she had assisted R15 up at 7:00 a.m. and pointed to a white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B verified 7:00 a.m. was noted on the board. NA-B confirmed she had not provided turning and repositioning assistance for R15 since 7:00 a.m. (three hours and 30 minutes earlier). NA-B referred to the NA worksheet which she removed from her pocket and verified R15 was to be repositioned every hour. NA-B stated even though R15 could tell us she needed help, it was staff's responsibility to provide the cares without R15 having to ask us. | F 314 | | |

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| F 314 | Continued From page 52<br><br>On 3/22/17, at 11:10 a.m. the DON confirmed R15 should have been repositioned every hour as directed by the care plan.<br><br>A Resident Care Planning Policy and Procedure, reviewed 4/2015, indicated the care plan was to promote optimal resident independence and quality of care by focusing and directing staff efforts to individual needs and to promote appropriated utilization and coordination of services.<br><br>The Pressure Ulcer Prevention Policy dated 4/2015, indicated the facility pressure ulcer prevention protocol included but was not limited to development of turning and positioning schedules of at least every two hours or more often if condition indicates.<br><br>Facility protocol Skin Care last reviewed 1/2015, indicated on admission a comprehensive skin assessment would be completed and used to develop a comprehensive care plan. The components of the comprehensive assessment included a Braden's scale weekly times four weeks, skin assessment-completed with the initial admission assessment, assessment for pressure relieving devices and a tissue tolerance test assessment. Other scheduled assessments included the Braden's scale quarterly and with significant change in status, skin assessment with significant change status, weekly body audit on bath days, Tissue Tolerance Test with a significant change in condition. The protocol also indicated staff would apply moisture barrier cream | F 314 | | |

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| F 314 | Continued From page 53<br>to perirectal area daily, as needed. | F 314 | | |
| F 323 SS=G | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess falls in order to identify causal factors and implement fall interventions in order to minimize the risk for falls and/or injury for 2 of 4 residents (R64, R88) who had repeated falls. This failure resulted in actual harm for R64. | F 323 | **F 323**<br><br>A new fall risk assessment was completed on resident 64 on 4/24/17. Resident 64's fall interventions were reviewed on 4/26/17 and new interventions were added.<br><br>Resident 64's falls were re-assessed for causative factors on 4/26/17 and changes were made to his/her plan of care on 4/26/17.<br><br>A new fall risk assessment was completed on 4/24/17 on resident 88. Resident 88's fall interventions were reviewed on 4/26/17.<br><br>Resident 88's falls were re-assessed for causative factors on 4/26/17.<br><br>All resident's fall interventions will be reviewed prior to 5/2/17 to ensure appropriateness.<br><br>All charge nurses will be educated on the importance of comprehensively assessing resident falls for causative factors as well as completing an evaluation of the resident's current fall interventions to assess for effectiveness prior to 5/2/17. | |

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| F 323 | Continued From page 54<br><br>Findings include:<br><br>R64's undated Face Sheet indicated R64's diagnoses included Alzheimer's disease, anxiety, dizziness, seizures, depression, obesity, macular degeneration (poor vision) , cataracts, psychosis, delusional disorder and dementia.<br><br>R64's annual Minimum Data Set (MDS) dated 10/2/16, and quarterly MDS dated 12/20/16, indicated R64 had severe cognitive impairment, wandered, had inattentiveness, required extensive assist with toileting and dressing, limited assist with walking in room and corridor, was frequently incontinent of urine, had functional limitations with range of motion of upper extremities bilaterally, and was not steady but able to stabilize herself without human assistance when moving from a sit to stand position and on and off the toilet.<br><br>R64's Falls Care Area Assessment (CAA) dated 10/2/16, indicated R64 also had a Bi-polar diagnosis and was a fall risk due to impaired balance during transfer transitions, R64 had received daily doses of an antipsychotic and a diuretic medication, R64 had wandering behavior daily and had sustained nine falls since the last assessment period. In addition, R64 was at risk for falls which could result in fractures, head injury, soft tissue injury, muscle injury and discomfort. Complicated by Alzheimer's dementia and psychosis. | F 323 | The facility's Assessment After a Fall policy was reviewed on 4/19/17.<br><br>The facility's Fall Prevention Policy was reviewed on 4/19/17.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure all resident falls are assessed for causative factors, that an intervention is implemented after each fall, and that interventions are assessed for their effectiveness. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 323 | Continued From page 55<br><br>R64's Cognitive Loss/Dementia CAA dated 10/2/16, indicated R64's unexplainable behavior may be an attempt at communication about pain, toileting needs, uncomfortable position etc. the CAA also indicated R64 had physical behaviors with other residents which may be a way of R64 communicating a need of some kind. R64 had inattention that fluctuated, was at risk for confusion, and increased behaviors, falls and isolation. Complicate by Alzheimer's disease, dementia with behavior disturbances and Bi-polar mood disorder. Staff will proceed to provide cues and supervision when decision making.<br><br>R64's Urinary Incontinence CAA dated 10/2/16, indicated R64 required extensive staff assist for toileting and was frequently incontinent. The CAA does not identify an individualized toileting plan to be utilized.<br><br>R64's care plan reviewed on 3/16/17, indicated R64 was frequently incontinent of urine and directed staff to provide limited assistance every 1.5-2.5 hours and to check with toileting and change as needed. R64 had a potential for pain and directed staff to medicate R64 as ordered, use [unidentified] pain scale to assess pain, assist to position for comfort and to keep physician informed. R64 had decreased physical mobility with potential for falls with inability to ambulate to specific destinations at specific times in secured unit, wheel self, transfer self or turn and reposition self, sit up, lie down or get feet and legs into bed independently, wanders on secured unit. The plan directed staff to provide limited assist of one staff to ambulate on and off the unit | F 323 | | |

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| F 323 | Continued From page 56<br>with walker. Provide limited assist of one staff to transfer and also transfers self at times, utilize safety halos, and to refer to nursing orders (physician orders) for further fall interventions. A hand written, undated entry indicated a manual tilt in space wheelchair was to be utilized for comfort, positioning and safety. Restorative nursing as ordered.<br><br>R64's physician orders/nursing orders from 10/23/16, through 2/9/17, indicated the following fall prevention interventions were in place:<br>-lavender oil behind ears for relaxation twice a day (initiated 11/23/15)<br>-contour mattress with cut out (initiated 11/23/15)<br>-30 minute checks (initiated 2/19/16)<br>-admit to Maple Lane secure dementia unit due to wandering and elopement attempts.<br><br>R64's medical record and fall assessment reports between 10/23/16, and 3/19/17, revealed R64 had sustained the following 14 falls, one which caused serious injury (fall on 3/2/17):<br><br>1. R64's Fall Assessment dated 10/23/16, and corresponding Safety Event's - Falls note indicated R64 had fall which was witnessed in the hallway on 10/23/16, at 10:00 p.m. R64 had been wandering in the hallway and attempted to enter another resident's room when a staff member tried to stop R64 and another resident also grabbed R64 at the same time. R64 lost her balance, turned around, sat down on the floor and laid down. No injury noted with this fall. Orthostatic blood pressures were stable. | F 323 | | |

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| F 323 | Continued From page 57<br><br>The follow up fall note dated 10/24/16, at 1:06 p.m. indicated this had been R64's 17th fall this year, R64 was currently being treated for a urinary tract infection (UTI) which could have increased R64's risk for falls and R64 had lost her balance. Current fall prevention interventions in place were a contoured mattress with cutout and every 30 minute checks.<br><br>The Evaluation Note indicated by check marks only that a Fall Prevention Program was initiated, R64's pain was resolved and care plan was updated.<br><br>Although this incident was witnessed, R64's medical record lacked documentation of any new fall prevention interventions to be implemented.<br><br>2. R64's Fall Assessment dated 11/27/16, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall in the dining room on 11/27/16, at 7:45 p.m. R64 was found on the floor near the dining room after another resident had alerted staff R64 had fallen. R64 had not been using a walker. No injury was noted with this fall. Orthostatic blood pressure was stable. Plan was to check orthostatic blood pressure, blood sugar, lungs sounds, log and to monitor R64.<br><br>The follow up fall note dated 11/28/16, at 10:54 a.m. indicated this was R64's 18th fall this year, R64 always wore gripper socks, R64 ambulated | F 323 | | |

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| F 323 | Continued From page 58<br>with a walker most often, but staff needed to remind R64 to use it. It was not noted if R64 had been using the walker at the time of the fall. R64's fall prevention interventions in place remained the same. Staff does not plan to discuss use of a wheelchair for resident as staff felt R64's risks in the wheelchair were significantly worse.<br><br>Evaluation Notes indicated by a check mark only that a Fall Prevention Program was initiated, pain was resolved and care plan was updated.<br><br>R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following the 11/27/16, in order to minimize further falls and/or injury.<br><br>On 3/22/17, at 1:03 p.m. the director of nursing (DON) and registered nurse (RN)-B confirmed the above fall. However, stated both were on leave during this fall event. RN-B verified the family had requested R64 remain independent and walking. The DON stated the fall process included the fall would be discussed at the morning meetings- the falls committee which included unit managers, therapy, MDS nurse. If a fall occurred the fall committee talked about it on the next day and an action plan would be made and a follow up progress note was put into place. The DON stated on the weekend, the charge nurse would put immediate interventions into place, educate staff, if needed and document. As far as determining causal factors related to this | F 323 | | |

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| F 323 | Continued From page 59<br>fall, the DON stated was unable to comment on this as she was not in the facility at the time of the fall.<br><br>3. R64's Fall Assessment dated 11/30/16, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall in another resident's bathroom on 11/30/16, at 9:45 p.m. R64 was found in another resident's room on the floor in the bathroom. R64 sustained a bump on the back of her head. R64 had her walker with her and the lights in the bathroom had been off. Vitals were checked and R64 was assisted to bed. Staff indicated they had redirected R64 back to the TV room a couple of times prior to the fall.<br><br>The follow up fall note dated 12/2/16, at 11:04 a.m. (late entry) indicated R64 had a pattern to go to the end bathroom and wander through it, she ambulated independently with her walker on the unit, however she often forgot to use and staff would have to bring it to her. The staff had noted a significant change with R64's ability to find words and follow conversations. Family also reported an overall decline in R64. Staff concerned R64's overall decline in condition would continue and R64 would continue to fall, but it depended on what the family wanted for R64. Staff to discuss with family their desire to allow resident to continue to ambulate independently with her high fall risk. No further action noted and no further indication related to other cognitive declines.<br><br>Fall interventions remain the same. Plan was for staff to talk to R64's family about their desire for | F 323 | | |

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| F 323 | Continued From page 60<br>R64 to continue to ambulate independently.<br><br>The Evaluation Notes indicated by a check mark only that a Fall prevention program was initiated, pain was resolved and R64's care plan was updated.<br><br>R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following the fall in order to minimize the risk for further falls and/or injury.<br><br>On 3/22/17, at 1:19 p.m. following review of this fall, the DON confirmed no new interventions were put into place.<br><br>4. R64's Fall Assessment dated 12/4/16, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall in the TV/day room on 12/4/16, at 4:40 a.m. Staff were in the dining room and heard a thud noise. R64 was found flat on her back on the floor of the TV/day room. R64 appeared to have hit her head and had a bump on the back of her head. In addition, R64 had some bruising noted on her right shoulder, however it was unclear if these injuries were from this fall or the fall R64 sustained on 11/30/16.<br><br>The follow up fall note dated 12/8/16, at 11:19 a.m. (late entry) indicated staff was unsure of what could be changed to assure R64 could | F 323 | | |

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| F 323 | Continued From page 61<br>make it into the chair. The chairs were contrast with the flooring and R64 frequently sat in these larger recliner chairs. The note also indicated this was resident's 20th fall this year, Family wanted R64 to continue to ambulate as this helped with R64's overall anxiety. Family also felt R64 would fall from the wheelchair since she would not remember any safety techniques related to the wheelchair use. It was not noted if R64 had been utilizing the walker or not. The current fall prevention interventions remain unchanged. The family was concerned that R64 had a UTI at this time so staff would monitor R64 for signs and symptoms of a urinary tract infection (UTI).<br><br>The Evaluation Note indicated by a check mark only that a Fall prevention program was initiated, pain and injury were resolved and care plan was updated.<br><br>R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following the fall in order to minimize the risk for further falls and/or injury.<br><br>5. R64's Fall Assessment dated 12/23/16, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall in the TV room on 12/23/16, at 6:04 a.m. Staff heard a loud thud and found R64 sitting on the floor in front of the Christmas tree. R64 stated she fell. The staff felt R64 had attempted to sit down and missed the chair. R64 had a contusion to the middle back of her head, area was red and sore to the | F 323 | | |

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| F 323 | Continued From page 62<br>touch. Pain medication was given for headache. A drop in orthostatic blood pressure was noted and blood sugar was elevated so staff would recheck both. R64 was unable to state what happened other than she fell. The note does not identify if R64 was utilizing the walker or not.<br><br>The follow up fall note dated 12/23/16, at 10:05 a.m. indicated this was R64's 21st fall this year, current interventions remained the same. A physician order was obtained for a urinalysis and culture due to history of UTI's. R64's physician was on site and discussed R64's falls, current dementia status, UTI treatment and also overall condition. The physician indicated R64 could be at her maximum medication treatments so suggested a reduction even though R64 displayed symptoms of depression and anxiety. An order to reduce Klonopin (antianxiety with known side effects of dizziness and lowering the blood pressure) from 0.5 milligrams (mg) three times a day to 0.5 mg twice a day. No further documentation related to the increased blood sugar or change in orthostatic blood pressure was noted. Staff also talked to the family about having R64 use a wheelchair, however, the family stated the physician and rest of the family felt R64 was not ready to use a wheelchair and would fall from it.<br><br>The Evaluation notes indicated by a check mark that a Falls prevention program was initiated, pain was resolved, injury was resolved, and R64's care plan was updated.<br><br>Although R64's medical record identified R64's | F 323 | | |

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| F 323 | Continued From page 63<br>antianxiety medication (Klonopin) as a causal factor which could have contributed to R64's fall, the medical record lacked new interventions to be implemented in order to minimize the risk for further falls and/or injury.<br><br>6. R64's Fall Assessment dated 12/24/16, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall in the TV/day room on 12/24/16, at 10:50 p.m. A visitor had seen R64 on the floor and alerted staff. Staff found R64 seated on the floor in front of a chair in the TV/day room and staff "assumed" R64 had missed the chair when attempting to sit down. No injury was noted with this fall, however, R64 stated her feet hurt.<br><br>The follow up fall note dated 12/26/16, at 1:12 p.m. (late entry) indicated R64 had quite a history of falls, this was R64's 22nd fall of the year, R64 always wore gripper socks, and Occupational and Physical therapy were not needed because R64 was "stable on her feet" and unable to benefit from education due to memory loss. R64 had been participating in the restorative nursing program, a family conference was scheduled for 12/28/16, to discuss options, and staff were waiting the results of a urinalysis which had been sent on 12/24/16. Current fall prevention interventions remained the same, unchanged.<br><br>The Evaluations Notes indicated by a check mark that a Falls Prevention Program was initiated, pain was resolved, injury was resolved and care plan was updated. "Staff are assuming" R65 missed a chair when she was going to sit down. | F 323 | | |

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| F 323 | Continued From page 64<br>Family was aware of R64's fall risk and wanted R64 to continue to be able to ambulate.<br><br>R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following the fall in order to minimize the risk of further falls and/or injury.<br><br>7. R64's Fall Assessment dated 12/26/16, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 12/26/16, at 1:20 p.m. R64 was found in R64's bathroom on the floor. R64 stated she had slid off the toilet and R64's pants were down to the knee. R64 had some bruising on R64's right upper leg.<br><br>The follow up fall note dated 12/27/16, at 1:51 p.m. indicated this was R64's 23rd fall this year. Staff had just assisted R64 to the bathroom at 1:00 p.m. prior to the fall, R64's physician felt R64's body was at maximum level of medication tolerance and that something might be causing her falls related to her medications. R64 tired quickly and was encouraged to take frequent rest periods. Current fall prevention interventions included remained unchanged. R64 was stable with walking with her walker most often. However, the medical record indicated R64 did not remember to take the walker with her and required reminders or staff to bring the walker to her. Staff were waiting on the results of the urinalysis and culture (UA/UC) which had been obtained. (Based on the results of the UA/UC, | F 323 | | |

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| F 323 | Continued From page 65<br>R64 was not treated for a UTI)<br><br>Evaluation Notes indicated family wants R64 to continue to ambulate until family conference is held. Urine culture recently obtained, orthostatic blood pressures stable. Check marks indicated a Falls Prevention Program was initiated, Pain was resolved, and care plan was updated. No mention of R64's blood sugar was noted.<br><br>R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following this fall in order to minimize the risk for further falls and/or injury.<br><br>R64's Event report note dated 1/1/17, indicated a conference was held with four of R64's family members to discuss R64's falls. Family was given an update on R64's activities of daily living abilities/status and activities. R64 had an eye appointment set up for the month of 1/17, however, family did not feel R64 had any visual changes at this time. Staff would be adding activities on Maple Lane in which family felt would be beneficial as R64 enjoyed activities and liked to stay busy. The staff discussed with R64's family two overall options for R64 which was mainly to continue to ambulate as she currently was or to try a wheelchair for R64. Family's main concern was that a wheelchair be customized for R64 with a tilt mechanism. Discussion held on R64's frustration level if unable to get out of the wheelchair independently. Family feels R64 would | F 323 | | |

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| F 323 | Continued From page 66<br>not be able to get out of the wheelchair and they are "Ok" with this as long as R64 might be safer. Family asked about using the wheelchair on an as needed basis, however, staff informed the family that R64 was not a good resource to say if she was tired and needed to sit down and could not always verbalize needs in general, appropriately. The family confirmed this was a noticeable decline for R64 as she was unable to voice wants/needs and family often had to assume what R64 was trying to say to them. Staff talked about R64 continuing to ambulate with her walker as she currently was with the risk of her falling and breaking something as she had done in her past. Family agreed R64 was at high risk for injury and did not feel R64 would ever be able to pull through surgery to repair an injury and if R64 did require surgery, she would not return to her baseline status. Staff also discussed R64's medication changes like Aricept and also other psychotropic medications as well as possible side effects of stopping some of the medications that increased R64's fall risk. At this time, R64's family wants her to continue to ambulate with her walker and staff to watch out for her as best they could. Family also requested the facility move forward on ordering a customized wheelchair with leg rests and tilt function and to utilize it only on an as needed basis so R64 could still move as best as possible. Staff educated family on their inability to know when R64 would need the wheelchair due to her memory problems and also her inability to communicate accurately when she might need it. Staff informed family they would not know when R64 would be falling and when the wheelchair would need to be used. Staff could still ambulate R64 with assistance, however, the wheelchair would be the primary mode of transportation. Family was "OK" with this and | F 323 | | |

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| F 323 | Continued From page 67<br>understood the risks of placing R64 into a wheelchair. R64 was to be fitted for a customized wheelchair. On 12/29/16, family reported they wanted R64's Aricept stopped and R64's physician was notified. On 12/30/16, R64's physician was on site and discussed R64's falls in which he stated he did not have any suggestions on how to prevent further falls for R64. Also agreed with family's request to stop Aricept, however, requested staff notify R64's psych physician as well. Physician also reported R64's recent urine culture did not require treatment.<br><br>8. R64's Fall Assessment dated 12/28/16, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 12/28/16, at 5:45 p.m. R64 was found on the floor in another resident's room. R64 had been walking without the walker. No injury was noted with this fall.<br><br>The follow up note dated 12/29/16, at 1:11 p.m. indicated this was residents 24th fall this year, R64 had been walking without her walker and current fall prevention interventions remained unchanged. Following the 12/28/16, care conference the family agreed to have R64 fitted for a customized wheelchair which had been requested. Staff assist R64 with locating her walker when noted R64 was walking without it. The plan for this fall was to update the provider because R64 had been displaying more aggressive behaviors towards peers.<br><br>The Evaluation Notes indicated "staff are thinking | F 323 | | |

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| F 323 | Continued From page 68<br>she either tripped or slipped and this caused the fall." R64 was not using the walker and was unable to tell staff what caused her to fall. R64 was ambulatory with use of the walker and usually did quite well but does not always remember to use the walker and would leave it in various places on the unit. Continues to be followed by physician from the behavior center due to her use of psychotropic medications as well as her behaviors. Since the decrease in Klonopin, staff have noted an increase in aggressive behaviors which has impacted other residents on the unit. Falls Program initiated, R64's pain was resolved, injury resolved and care plan was updated.<br><br>R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following the fall in order to minimize the risk for further falls and/or injury.<br><br>9. R64's Fall Assessment dated 1/22/17, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 1/22/17, at 12:54 a.m. R64 was found kneeling down on the floor and leaning on a chair in the TV/living room area. R64 could not tell staff what happened. No injury but did state her knee hurt. Falls are occurring at night.<br><br>The follow up note dated 1/22/17, (untimed) indicated R64 was unable to tell staff what happened, R64 complained of her knee hurting, | F 323 | | |

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| F 323 | Continued From page 69<br>R64 had not used her walker, however, the walker was located nearby. Continue with the same fall prevention interventions. Plan was to request a scheduled Tylenol or ibuprofen for the knee pain which may have contributed to R64's fall. The medical record did not reveal if R64 had chronic complaints of knee pain.<br><br>Evaluation Notes indicated this was R64's first fall this new year and did not address history of numerous falls prior to new year however indicated It had been almost a month since R64's last fall which was an improvement for her. The same interventions continue. A check mark indicated a Falls Prevention Program was initiated, Pain was resolved, injury was resolved and care plan was updated.<br><br>R64's medical record lacked documentation of a comprehensive analysis of identified causal factors which contributed to this fall and no new fall prevention interventions were identified or implemented following this fall in order to minimize the risk for further falls and/or injury.<br><br>10. R64's Fall Assessment dated 1/22/17, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 1/22/17, at 9:20 p.m. (second fall on this day). R64 was found on the floor in another resident's bathroom doorway. R64 was unable to tell staff what she was doing at the time of the fall. No injury was noted with this fall. | F 323 | | |

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| F 323 | Continued From page 70<br>The follow up note dated 1/22/17, (untimed) indicated since R64 had been found in the bathroom and had been toileted less than an hour before this fall, post void residual checks would be completed to ensure R64 was emptying her bladder. Orthostatic blood pressure checks would be done and current fall prevention interventions included the use of a contour mattress with cutout, reminders for R64 to use her walker, every 30 minute checks, lavender oil and gripper socks.<br><br>Although post void residual was identified as possible causal factor for this fall, a comprehensive analysis was not conducted to identify causal factors of R64's repeated falls or interventions implemented in order to minimize the risk for further falls and/or injury.<br><br>11. R64's Fall Assessment dated 1/31/17, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 1/31/17, at 2:55 a.m. staff heard a loud noise and found R64 lying on the floor in the TV/living room area. R64 stated she was just trying to wake up. A fist sized bump was noted on the back of her head, right side. A hand written entry indicate read "? if weak legs r/t [related to] increased leg swelling could have contributed to fall."<br><br>The follow up note dated 1/31/17, at 2:16 p.m. indicated this was R64's 3rd fall this year. Current fall prevention interventions in place included the use of a contour mattress with cutout, every 30 minute checks, lavender oil twice a day, reminders to use the walker, and gripper | F 323 | | |

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| F 323 | Continued From page 71<br>socks.<br><br>The Evaluations notes indicated R64 was not using her walker at the time of the fall rather it was noted to be next to the chair she had been sitting in. Vital signs were stable. Had an elevated blood sugar. Occupational therapy was consulted for possibility of lymphedema treatment due to significant lower extremity edema which was implemented on 2/27/17. Staff had noticed R64 was having dysuria and cloudy, sediment filled urine therefore a urine culture was obtained. No further analysis was identified. Fall interventions remained the same. A check mark indicated a Falls Prevention Program was initiated, Pain was resolved, injury was resolved and care plan was updated.<br><br>R64's medical record indicated causal factors which may have contributed to R64's fall on 1/31/17, was R64's increased swelling in R64's legs, however, a complete analysis of the effectiveness of the interventions was not completed.<br><br>12. R64's Fall Assessment dated 2/9/17, and corresponding Safety Event's - Falls note indicated R64 had a witnessed fall on 2/9/17, at 9:45 a.m. R64 was walking out of the TV/Living room area without walker, turned around, wobbled, and was guided to the floor by a nursing assistant, however, it was not a controlled lowering to the floor. Urine was noted on the floor, unsure if the urine was there first but R64 was wet. No injury was noted with this fall. | F 323 | | |

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| F 323 | Continued From page 72<br><br>The follow up note dated 2/9/17, (untimed) indicated this was the R64's 4th fall this year, R64 had a UA/UC which was positive and was treated for a UTI (started antibiotics 2/10/17), R64 was also having lymphedema treatment which may benefit R64 because of the swelling in R64's feet and legs. Current fall prevention interventions were not noted.<br><br>Evaluation Notes indicated by a check mark that a Falls Prevention Program was initiated, pain was resolved and care plan was updated.<br><br>Although causal factors were identified as lymphedema and UTI. A complete analysis including the evaluation of current interventions in order to determine appropriateness was not completed.<br><br>R64's Fall Risk Assessment dated 2/23/17, indicated R64 was at high risk for falls as R64 had had three or more falls in the past three months, had taken more than three medications which could increase the risk for falls, and had predisposing diseases such as seizures which could also increase R64's risk for falls. No new fall interventions were identified and staff were directed to continue with the current fall interventions with no changes at this time. Although a fall risk assessment was completed, it failed to identify what could be done about the risk factors placing R64 at high risk or evaluate the efficacy of the current interventions as they | F 323 | | |

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| F 323 | Continued From page 73<br>related to those identified risk factors.<br><br>13. R64's Fall Assessment dated 3/2/17, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 3/2/17, at 2:05 a.m. Staff had assisted R64 into the bathroom by the TV/Living room area. The staff member told R64 she would be right back and left R64 unattended in the bathroom to retrieve a new brief from R64's room. Staff heard R64 calling for help and found R64 laying on the floor. R64 was unable to state what happened to cause her to fall. Staff felt R64 either tipped off the toilet or attempted to get up from toilet and fell. R64 was sent to the emergency room and was found that have sustained a nose and wrist fracture (and later identified a rib fracture). Gripper socks were on at the time of the fall. Similar falls occurred at night time. R64's sleep issues were reported to the physician. Staff had been discussing plans in regards to R64's falls with her family.<br><br>The follow up note dated 3/2/17, 3:31 p.m. and Evaluation Notes dated 3/2/17, indicated a customized wheelchair had been ordered for R64 which had not yet arrived. R64 was treated for a UTI in 2/17. R64 has had significant falls over the last year. Staff had been updating her physicians' related to falls and discussion had been held with family related to R64's falls. R64 remained on every 30 minute checks for quite some time and utilized a contour mattress with cutout. Staff monitor for pain signs and symptoms every four hours. R64 ambulates on the secured unit with the assistance of a walker. R64 had been started on daily weights and had been placed on a short | F 323 | | |

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| F 323 | Continued From page 74<br>course of increased diuretics because of the concern with the fluid in R64's feet and legs which placed R64 at increased risk for falls. R64 had received lymphedema treatment. R64's vital signs and orthostatic blood pressure, blood sugar and lungs sounds were to be checked however the results of these checks were not indicated. New fall prevention interventions identified and implemented included R64 should have someone close by her at all times, R64 was not to be left alone on the toilet, R64 was to use a wheelchair when moving about, anti-rollback's should be on R64's wheelchair, and R64 should use the manual tilt and space wheelchair for positioning, comfort and safety. R64's medical record lacked a correlation of the number of falls surrounding toileting and a toileting plan assessment was not noted following the falls. R64's physician orders revealed R64 was to wear an Ace wrap to left wrist at all times until further notice. If R64 was walking with her walker, she should have assistance close by at all times due her high risk for falling, and orthostatic blood pressures daily.<br><br>Evaluation Notes indicated by a check mark that a Fall Prevention Program was initiated, pain and injury was resolved and care plan was updated. No further information noted related to new fractures and pain control.<br><br>Causal factor was speculated to be due to R64's increase in swelling in R64's legs, however, a comprehensive root cause analysis was not completed and interventions leading up to the fall were not evaluated for effectiveness. | F 323 | | |

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| F 323 | Continued From page 75<br>14. R64's Fall Assessment dated 3/19/17, and corresponding Safety Event's - Falls note indicated R64 had an unwitnessed fall on 3/19/17, at 2:20 a.m. R64 was found sitting on the floor in another resident's room. A few minutes prior to the fall, R64 was seated on a chair by the nurse's station. Staff had assisted R64 to the bathroom at 2:15 a.m. R64 was unable to tell staff what she was trying to do at the time of the fall and facility staff were unable to determine cause of fall. Vitals signs were stable. No injury was noted with this fall.<br>R64's customized wheelchair had been received and staff were working with R64 on use. R64 was noted to have troubles adjusting to the wheelchair but staff were continuing to encourage use. Staff continue to provide every 30 minute visual checks and have been attempting various avenues to help keep R64 safe and to identify root cause of falls, however, R64 continued to fall. Psych physician started new medication due to periods of crying and laughing. Similar falls occurred at night. Even though R64's 3/2/17, new intervention indicated she was supposed to have someone close to her at all times, R64 had an unwitnessed fall.<br><br>The follow up note dated 3/20/17 (no time) indicated R64 received a new wheelchair and staff have encouraged R64 to use it. Provider reviewed R64's medication and started Nuedexta (a medication to treat involuntary outbursts or crying or laughing for certain neurological disorders) and current fall prevention interventions included: R64 should have someone close by her at all times, R64 was not to be left alone on the toilet, R64 was to use a wheelchair when moving about, anti-rollback's | F 323 | | |

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| F 323 | Continued From page 76<br>should be on R64's wheelchair, and R64 should use the manual tilt and space wheelchair for positioning, comfort and safety and every 30 minute checks.<br><br>The Evaluation Notes indicated by a check mark a Fall Prevention Program was initiated, pain was resolved and care plan was updated.<br><br>On 3/21/17, at 1:50 p.m. R64 was observed seated in the TV/living room area, seated in a hard back chair. R64's walker was in front of her and R64 had non-skid slippers on. R64 had black/blue bruises noted under each eye, on the bridge of R64's nose, and upward onto R64's forehead. R64 had an ace bandaged on her left wrist.<br><br>On 3/22/17, continuous observations were made from 7:05 a.m. until 9:20 a.m.<br><br>-At 7:05 a.m. R64 was observed dressed and seated in a dining room hard back chair. The restorative aide was performing exercises with R64. R64 was very engaged with staff. R64's daughter was also visiting. The black and blue marks remain under her eyes and forehead. R64's legs are very edematous. No ace wrap noted on her legs. R64 had gripper socks on her feet and does not have an ace wrap on either wrist.<br><br>-At 7:15 a.m. R64 remained at dining room table, visiting with daughter. Restorative nursing had | F 323 | | |

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| F 323 | Continued From page 77 | F 323 | | |

been finished. R64 had remained in her chair throughout the exercises. Daughter mentioned R64 did not have her wrap on her wrist. Licensed Practical Nurse (LPN)-B stated R64 had taken it off during the night and would not let the night nurse put it back on. R64 remained seated in the chair visiting with her daughter until 7:48 a.m. at which time her daughter had left.

-At 7:56 a.m. R64 remained seated at the dining room table. NA-F approached R64 and placed a clothing protector on her.

-At 8:03 a.m. NA-G served R64 her breakfast of pancakes. R64 had been dozing in the chair however was awoken by NA-G. R64 proceeded to start eating her pancakes. R64 remained at the table, eating her breakfast until 8:39 a.m.

-At 8:39 a.m. NA-F approached R64, removed her clothing protector and asked R64 if she needed anything else. R64 stated she did not know what to do. NA-F informed R64 she was okay sitting right where she was and directed R64 to "sit back and let her food settle."

-At 8:43 a.m. R64 was restless and fidgety. NA-F approached R64, provided her the walker and offered R64 to go to the bathroom in which R64 stated she did not have to go to the bathroom. NA-F guided R64 into the living room area. R64 became tearful, NA-F tried to reassure R64 and assisted R64 into a recliner, elevated the feet of the recliner and placed a light blanket over R64. R64 does not have ace wraps on her wrist or legs.

-At 8:55 a.m. R64 remained seated in the recliner in the living room area. R64 told NA-F that her

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| F 323 | Continued From page 78<br>legs were cold. NA-F asked R64 if she wanted to have her legs wrapped up. R64 replied "yes." NA-F informed LPN-B R64 wanted her legs wrapped.<br><br>-At 9:00 a.m. LPN-B applied Ace wraps to lower extremities. R64 stated she had to go to the bathroom.<br><br>-At 9:17 a.m. LPN-B lowered recliner foot rest, placed the walker in front of R64 and assisted R64 into an upright position. LPN-B assisted R64 into the bathroom and remained with R64 until they both exited it at 9:20 a.m.<br><br>On 3/22/17, at 12:26 p.m. R64 was observed walking independently without the walker into the dining room area. NA-F scurried to R64's side and assisted R64 into R64's wheelchair.<br><br>On 3/22/17, at 1:03 p.m. the DON and RN-B both confirmed the aforementioned falls and corresponding notes. On 3/23/17, at 2:15 p.m. the DON verified R64 was at a high risk for falls and recognized the majority of R64's falls had occurred in the bathroom or TV/living room area and at night. The DON stated R64 had nights that she did not sleep well therefore staff were using lavender oil and allowing her to sleep in the recliner. She also stated a float NA could sit with residents on the unit if needed, and the facility would be changing lighting levels as the day went on. The DON stated staff should have identified the root cause of the falls and developed individualized fall prevention interventions for R64 | F 323 | | |

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| F 323 | Continued From page 79<br>in order to prevent reoccurring falls. The DON confirmed part of the post fall follow up evaluation process should have included a review of R64's current fall prevention interventions and an evaluation of those interventions to determine if they were appropriate, effective and sustainable. The DON verified prior to R64's fall on 3/2/17, which resulted in fractures, the only fall prevention interventions documented on R64's physician orders or R64's care plan were lavender oil behind the ears for relaxation twice a day (initiated 11/23/15), contour mattress with cut out (initiated 12/28/15), and 30 minute checks (initiated 2/19/16). In addition, the DON confirmed when R64's potential causal factors for falls were ruled out, the facility failed to reevaluate R64's fall to determine the root cause for R64's falls.<br><br>On 3/23/17, at 8:31 a.m. NA-E stated R64 had a new wheelchair which tilted and R64 seemed to like. If R64 went to the bathroom, staff were supposed to stay with her. If she got up and started walking, staff were to walk with her and make sure R64 had her walker with her. Staff were to keep a frequent eye on R64. If R64 was restless, it usually meant she had to use the bathroom.<br><br>R88's undated Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, myelodysplastic syndrome, and anxiety disorder.<br><br>R88's admission MDS dated 12/18/16, indicated R88 had severe cognitive impairment, required | F 323 | | |

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| F 323 | Continued From page 80<br>extensive assistance from two staff for bed mobility and toileting, required extensive assist from one staff for transferring and personal hygiene, had impaired balance and functional limitations in range of motion in one upper extremity. The MDS further indicated R69 was frequently incontinent of urine, had a fall prior to admission with fracture within the last six months, and had two falls at the facility since admission.<br><br>R88's Fall CAA dated 12/15/16, indicated R88 had impaired balance, was unsteady, required staff assistance for ambulation, history of falling prior to admission, cervical spine and clavicle fracture, dementia, weakness, and had two falls since admission to the facility. The CAA indicated R88 was at risk for more falls with injury. Being unsteady with transition and while ambulating and needing staff assist to steady him. Resident has a history of falling prior to his admission and he also had two falls since his admission. Was at risk for more falls, soft tissue or muscle injury, head injury, fracture and discomfort. Complicated by history of falling.<br><br>R88's Fall Risk assessment dated 12/15/16, indicated R88 required two assist for ambulation, used the wheelchair for main mode of transportation and orthostatic blood pressures were not able to be completed related to weakness. The assessment indicated R88 was at high risk for falls. A copy of this assessment was requested and not received.<br><br>R88's care plan dated 12/28/16 indicated R88 had a potential for falls related to decreased | F 323 | | |

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| F 323 | Continued From page 81<br>mobility, history of falling, had a cervical spine and clavicle fracture, and required assistance from staff for activities of daily living. The fall goal listed indicated R88 would maintain ability to ambulate per ambulation program. The interventions included the following:<br><br>-provide extensive assist of 1 to turn and reposition every two hours<br>-assist to sit up/lie down and get feet and legs into bed<br>-extensive assist of one to transfer and ambulate with walker<br>-staff wheel to all destinations.<br>-refer to nurses orders for fall interventions<br>-monitor for persistent red areas and notify the registered nurse<br>-Resident to wear soft collar as ordered.<br>-Physical therapy five times a week.<br><br>R88's monthly ADL (activities of daily living) Flowsheet reflected interventions for falls that included:<br><br>-Low, Low bed, start date of 2/2/17<br>-Mat at bedside, start date of 2/2/17<br>-Check resident every 30 minutes to ensure soft neck collar is in place, start date 2/20/17<br>-Mattress at bedside, start date of 2/3/17<br>-can't be in room unsupervised unless lying down, start date 12/20/16<br><br>R88's undated nursing assistant care guide sheet informed staff, R88 was a fall risk, could not be left unsupervised in his room unless in bed, turn and reposition every two hours, contour mattress with cutout, low bed, bed against the wall, | F 323 | | |

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| F 323 | Continued From page 82<br>mattress at bedside and mat, and every thirty-minute checks.<br>R88's falls record included:<br><br>1. R88's Fall Assessment dated 12/18/16, and corresponding Safety Events, indicated on 12/18/16, R88 sustained two falls. The first fall occurred at 9:25 p.m. when resident was found crawling on his hand and knees in his room and was unsure where he was going, however indicated he rolled out of bed and had increased confusion. The second fall occurred at 10:00 p.m. when the R88 was found on the floor without nightgown or brief on and R88 indicated he had been trying to go the bathroom. Neither incident resulted in injuries. The Fall Assessment indicated the following interventions were in place at the time of the falls:<br><br>-low, low bed<br>-mats at bed side<br>-contour mattress with cutout<br>-every ½ hour checks.<br>The fall assessment indicated the plan to prevent or reduce the risk of falling included<br>-check for urinary tract infection<br>-moved bed against the wall<br>-sleep study<br><br>R88's monthly ADL flow sheets indicated the following interventions were not added until 2/2/17: bed against the wall, low bed, and fall mats at bedside.<br><br>R88 sustained one witnessed and two unwitnessed falls between 2/17 and 2/18/17. | F 323 | | |

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| F 323 | Continued From page 83<br><br>2. R88's Fall Assessment and corresponding Safety Events dated 2/20/17, indicated on 2/17/17, at 6:15 p.m. R88 scooted out of his wheelchair and landed on his hands and knees on the floor, wanted to call his wife, the fall was witnessed, and no injuries were noted. Documentation reflected the Fall Assessment was not completed until three days after the fall and indicated the plan would be to add anti-rollback device for the wheelchair.<br><br>3. R88's Fall Assessment and Corresponding Safety Events dated 2/20/17, indicated on 2/18/17, at 7:30 a.m. and at 9:00 a.m. the resident was found sitting on the floor in front of wheelchair. The assessment indicated the falls were unwitnessed and no injuries sustained. The assessment indicated the plan was to add wedge cushion or dycem to the wheelchair.<br><br>The record indicated these falls were not comprehensively assessed for causal factors and fall interventions were not put into place until 2/20/17.<br><br>On 3/20/17, at 7:25 p.m. R88 was observed lying in bed. The bed was in the lowest position. The mattress on the bed was contoured with a cutout at midpoint of the mattress. Next to the bed was two regular bed mattresses taped together with duct tape, the fall mat was noted to be up against the wall, not down next to the mattresses, however at 7:35 p.m. the mattress was noted to be next to the doubled mattress. | F 323 | | |

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| F 323 | Continued From page 84<br><br>On 3/22/17, at 7:06 a.m. R88 observed lying in bed. The bed was in low position and the doubled mattresses were next to the bed with the fall mat next to the mattresses.<br><br>-At 3:28 p.m. NA-K was unable to articulate R88's fall interventions but stated R88 had a low bed and required a mattress next to his bed.<br><br>On 3/23/17, at 10:33 a.m. The DON explained after a fall occurred staff were to complete the in house worksheet for falls and try to figure out why the fall occurred. After they finished the worksheet they would enter the information from the worksheet onto the Event tracking and write a progress note. The DON indicated the information reviewed by the falls committee and the committee attempted to determine the root cause of the fall, reviewed the care plan for effectiveness of the interventions and changed as necessary. The DON stated if the falls occur over the weekend, the falls committee would not review until Monday, however in the meantime the RNs that worked during the weekend would look at the fall to ascertain if any immediate interventions could be put into place.<br><br>-At 1:17 p.m. RN-C stated the falls that occurred on 2/17, and 2/18, were not assessed until Monday, 2/20/17. The intervention that was immediately put into place according to the progress note indicated R88 received one to one services for the shift on 2/18, and on 2/19, as staff had R88 up by the nurse's station. RN-C indicated the RNs assessed his needs for fall interventions shift by shift. RN-C indicated | F 323 | | |

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| F 323 | Continued From page 85<br>interventions should be on the care plan or nursing assistant care guide.<br><br>Assessment after a Fall policy dated 4/2015, indicated all falls would carefully be assessed. The staff were directed to review each fall to determine the root cause of the fall and to plan for solutions. All falls would be tracked to determine trends. Each resident would have a fall monitoring log completed and reviewed after each fall. Interventions would be added to the nursing orders so that staff could track what had been tried with the past falls, what had worked, and what had not worked.<br><br>Fall Prevention policy dated 4/2015, indicated it was the policy of the facility to identify residents who were at high risk for falls and develop individual fall precautions for these residents. A post fall assessment would be completed after each fall and any changes in interventions would be noted on the form, in the resident's nursing orders, alarms would be added to the care plan, staff assignment sheets, if appropriate, and in the nurses' notes. The falls team would develop appropriate interventions to reduce further falls. | F 323 | | |
| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or | F 329 | **F329**<br><br>Resident 88's care plan was reviewed and revised on 3/22/17 to reflect the concern of insomnia and the non-pharmacological interventions for this problem. Resident 88's care plan was revised to include individualized non- | |

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| F 329 | Continued From page 86<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(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;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to follow physician's orders for the administration of as needed (PRN) sleep medication, failed to identify and differentiate target behaviors for administration of PRN mood stabilizer and antipsychotic medications, and failed to ensure documentation | F 329 | pharmacological interventions for pain as well. Resident 88's behaviors were reviewed and staff identified his target behaviors as well as individualized non-pharmacological interventions.<br><br>All resident's care plans will be reviewed and revised prior to 5/2/17 to ensure non-pharmacologic interventions are listed on all resident's care plans for insomnia as well as pain.<br><br>The pharmacy consultant will complete a review of all of the resident's current medication orders for unnecessary medications on 5/1/17. This included resident 88's medication orders. All psychotropic medications will be reviewed prior to 5/2/17 for nonpharmacological interventions and will be added if indicated.<br><br>Education will be provided to all charge nurses prior to 5/2/17 regarding adding nonpharmacological interventions to care plans and medication orders for pain and behavior management. All nurses will also be educated on the importance of documenting behaviors and the non-pharmacological interventions attempted prior to administering a prn medication prior to 5/2/17. | |

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| F 329 | Continued From page 87<br>of non-pharmacological interventions attempted or offered prior to the administration of PRN medications. In addition, the facility failed to ensure a nurse, (or other qualified professional) assessed the need for PRN administration and a nurse (or other qualified professional)evaluated the effectiveness of all administered PRN medications. Furthermore, the facility failed to develop a plan of care for impaired sleep integrity and revise the plan of care for pain to include individualized non-pharmacological interventions for 1 of 5 residents (R88) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R88's undated Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, overactive bladder, myelodysplastic syndrome, diverticulitis, and anxiety disorder.<br><br>R88's 14 day Medicare Minimum Data Set (MDS) dated 12/25/16, indicated R88 had severe cognitive impairment, mild depression, had trouble falling asleep, staying asleep, or sleeping too much. The admission MDS dated 12/18/16, indicated an increase in depressive symptoms from minimal depression with a score of 4 and also indicated R88 did not have trouble with sleep. The MDS indicated R88 displayed behaviors daily not directed towards others and was taking an antidepressant medication.<br><br>R88's care plan dated 12/28/16, indicated R88 | F 329 | Immediate education was provided to all TMAs, LPNs, and RNs on 3/23/17 regarding the completion of an assessment by a nurse prior to administering a prn medication. Education was also completed on the evaluation of the effectiveness of a prn medication needing to be completed by a nurse.<br><br>Education will be provided to all TMAs, LPNs, and RNs regarding following MD orders prior to 5/2/17.<br><br>Education will be provided to all Registered Nurses regarding care plan development prior to 5/2/17.<br><br>The facility's policy on nursing care plans was revised on 4/17/17. The facility's policy on psychotropic medication monitoring was reviewed on 4/25/17.<br><br>IDT meetings will be completed every month with the director of nursing (or designee) and pharmacy consultant. The purpose of these meetings is to eliminate unnecessary medications, identify target behaviors, and develop individualized interventions for each resident.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to | |

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| F 329 | Continued From page 88<br>had an alteration in thought process with potential for anxiety related to dementia/impaired cognition and nursing home placement. R88 displayed behaviors such as yelling out, swearing, attempting self-transfers, disrobing, resistive to treatment/cares, hitting out at staff, removing neck brace and arm sling. Interventions directed staff to assist R88 to activities, medicate as ordered, assess pain, offer snack, offer to use toilet, provide movie and music (country western Willie Nelson and Patsy Kline), allow time to express concerns and offer to talk with his daughter, reorient and validate as needed, anticipate needs, provide cues and supervision when making poor decisions.<br><br>R88's current physician orders included:<br><br>-Neurontin 100 mg (milligrams) three times a day for low back pain at 8:00 a.m., 2:00 p.m., 8:00 p.m.<br>-Neurontin solution 250mg/5ml (milliliters) give 50 mg every 2 hours PRN for pain, anxiety, restlessness. Max of 6 as needed doses in 24 hours.<br>- Oxycodone 2.5 mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. for low back pain<br>-Tylenol 1000mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. for low back pain<br>-Trazodone 50 mg at 8:00 p.m. every night for trouble sleeping, may give one additional tablet PRN after scheduled dose prior to 3:00 a.m.<br>-Effexor extended release 3 capsules every evening at 5 p.m. for anxiety disorder<br>-Seroquel 12.5 mg three times a day at 12:00 p.m., 5:00 p.m., 8:00 p.m. and 12.5 mg PRN for paranoia/agitation not to exceed two as needed doses in 24 hours. Use only when | F 329 | ensure care plans are updated when changes occur. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 329 | Continued From page 89<br>non-pharmacological measures such as offer of snack or drink, toileting, repositioning, massage, distraction with conversation or activity have failed (This order was revised on 3/17/17, to include use of non-pharmacological interventions).<br><br>Trazadone for sleep:<br><br>R88's Medication Administration Record (MAR) from 2/20-3/21/17, revealed the following PRN doses of Trazodone were administered (documentation reflected all scheduled doses given per order):<br><br>-2/21 PRN dose administered at 2:53 a.m. for restlessness, result was semi effective. The record lacked documentation of non-pharmacological interventions attempted or offered prior to administration.<br>-2/23 dose administered at 7:04 p.m. for restlessness and was effective however, dose was not given according to physician orders and the record lacked documentation of non-pharmacological interventions attempted or offered prior to administration.<br>-2/28 PRN dose administered at 4:43 p.m. for yelling and unable to redirect however, dose was not given according to physician orders and lacked evidence of non-pharmacological interventions attempted or offered prior to administration. The TMA (trained medication assistant) documented the medication was effective.<br>-3/5 PRN dose administered at 4:36 p.m. for yelling and hollering out, not able to redirect, dose | F 329 | | |

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| F 329 | Continued From page 90<br>was semi effective however, dose was not given according to physician orders and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration.<br>-3/7 PRN dose administered at 9:19 p.m. given for yelling out and hollering, not able to redirect, documented as effective. The medical record lacked documentation that a nurse assessment was conducted prior to and after the administration of the medication and the medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/10 PRN dose administered at 1:59 a.m. and was noted as effective, however, the MAR lacked documentation of the reason for administration and also lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/11 PRN dose administered at 1:50 a.m. for yelling and hollering out and was noted as semi effective however, the MAR and medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/13 PRN dose administered at 1:35 a.m. for hollering and was noted as semi effective however, the medical record and MAR lacked documentation of non-pharmacological interventions offered or attempted prior to the administration of the medication.<br>-3/15 PRN dose administered at 7:00 p.m. for yelling and was noted as not effective. The dose was not given according to physicians orders and lacked documentation of non-pharmacological interventions attempted or offered prior to the | F 329 | | |

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| F 329 | Continued From page 91<br>administration of the medication.<br>-3/16 and 3/21 doses administered for yelling and hollering out. The MAR and medication record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br><br>The facility failed to follow physician orders for administration of the Trazadone and lacked documentation of non-pharmacological interventions offered or provided prior to administration and failed to ensure a nurse assessment was conducted prior to and after administration of doses administered by trained medication assistant (TMA). In addition, the facility failed to develop a care plan for impaired sleep which would include non-pharmacological interventions.<br><br>Neurontin for pain, anxiety, and restlessness<br><br>R88's medical record did not reflect a differentiation between target behaviors for the administration of Neurontin for pain and for the administration of Seroquel (antipsychotic) or identify which target behaviors were associated with symptoms of anxiety and restlessness versus symptoms of paranoia and agitation in order to determine appropriate medication to administer. Target behaviors identified and monitored included: crying out, attempting to stand without help, and potential for combative with cares.<br><br>R88's Medication Administration Record (MAR) | F 329 | | |

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| F 329 | Continued From page 92<br>from 2/20-3/21/17, revealed the following as needed doses of Neurontin were administered:<br><br>-2/27 PRN dose administered at 4:20 p.m. for behavioral issue and pain, was semi effective. Medical record lacked behavior and pain documentation and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/3 PRN dose administered by TMA at 3:04 p.m. for bottom hurting and headache, was not effective. Medical record lacked documentation of a nurse assessment prior to the administration in order to assess need and also lacked nurse evaluation of the effectiveness of the medication. TMA indicated non-pharmacological interventions attempted prior to the administration for the bottom pain was repositioning every two hours and applying barrier cream, however no measures were indicated for the headache.<br>-3/5 PRN dose administered at 4:51 p.m. for bottom pain, anxiousness and agitation, and was semi-effective. The medical record lacked behavior and pain documentation and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/8 PRN dose was administered at 1:32 p.m. for yelling out and was effective. The medical record lacked documentation of behavior and of non-pharmacological interventions attempted or offered prior to administration.<br>-3/9 PRN dose administered at 9:47 a.m. for pain rated a six out of 10 pain scale and was not effective because resident spit out the medication. The medical record lacked pain documentation and lacked documentation of non-pharmacological interventions attempted or | F 329 | | |

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| F 329 | Continued From page 93<br>offered prior to the administration of the medication.<br>-3/13 PRN dose administered at 1:22 p.m. for screaming about and butt pain. The med was effective. The medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/15 PRN dose administered at 10:26 p.m. for hollering and hitting and was effective. The medical record lacked documentation of non-pharmacological intervention offered or attempted prior to the administration.<br><br>The facility failed to identify specific target behaviors associated with symptoms with anxiety and restlessness in order to justify the administration of as needed doses of Neurontin, and failed to ensure complete documentation of behaviors. In addition, the facility failed to ensure a nurse assessed R88 prior to and after administration of all PRN doses administered by the TMA, and failed to document non-pharmacological interventions prior to administration of the PRN doses. In addition, the facility failed to revise a care plan for pain to include non-pharmacological interventions.<br><br>Seroquel for paranoia/agitation:<br><br>R88's pharmacy record indicated on 3/1/17, the consultant pharmacist informed the facility the PRN dose of Seroquel required identification of target behaviors and non-drug (non-pharmacological) interventions to be attempted prior to administration of the | F 329 | | |

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| F 329 | Continued From page 94<br>medication. The report also indicated the physician need not be contacted, but nursing staff should address as soon as possible (a copy of the pharmacists' recommendation was requested and not received). The physician's orders reflected the direction to use non-pharm interventions prior to administration of medication was not added until 3/17/17.<br><br>R88's record did not reflect a differentiation between target behaviors for the administration of Seroquel and for the administration of Neurontin or identify which target behaviors were associated with symptoms of anxiety and restlessness versus symptoms of paranoia and agitation in order to determine appropriate medication. Target behaviors identified and monitored included: crying out, attempting to stand without help, and potential for combative with cares.<br><br>R88's nursing progress notes, daily documentation of behavior monitoring, and the MAR were reviewed from 2/20-3/21/17, and revealed the following documentation on administration of the as needed Seroquel:<br><br>-2/21 at 2:53 a.m. dose administered for behavioral issues and was semi effective. The medical record lacked documentation of behavior displayed and non-pharmacological interventions attempted prior to the administration.<br>-2/21 progress note entered at 1:06 p.m. indicated R88 received as needed Seroquel for behaviors this shift. Medication appears to be effective. However, the record lacked documentation of the time administered, behavior | F 329 | | |

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| F 329 | Continued From page 95<br>displayed and non-pharmacological interventions attempted or offered prior to administration.<br>-2/26 at 9:58 p.m. dose administered for behavioral issues and was not effective. The medical record lacked documentation of behavior displayed and non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-2/27 at 4:20 p.m. for behavioral issues and was semi effective. The medical record lacked documentation of behavior displayed and non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/1 progress note entered at 5:53 p.m. indicated a dose was given at that time for yelling out and causing disruptions. No further information was evident in the record. Documentation lacked evidence non pharmacological interventions were offered or attempted prior to the administration of the medications and an evaluation of effectiveness of administered dose.<br>-3/5 progress note entered at 9:08 p.m. indicated a dose was administered around 4:00 p.m. by a TMA for hollering out and did not respond to redirection. Documentation lacked time of administration and lacked a nurse assessment of the behavior prior to and after administration of medication. In addition, the record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication and lacked an evaluation of medication effectiveness.<br>-3/7 progress note entered at 9:28 p.m. indicated a dose was administered by a TMA for hollering out help me and was not able to redirect. Documentation lacked time of administration and lacked a nurse's assessment of behavior prior to and after administration of medication. In | F 329 | | |

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| F 329 | Continued From page 96<br>addition, the medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication and lacked evaluation of medication effectiveness.<br>-3/11 progress note entered at 6:47 p.m. and progress noted 3/12 at 4:40 a.m. indicated a dose was administered for yelling and hollering. The medical record lacked time of dose, non-pharmacological interventions attempted or offered prior to the administration of the medication and an evaluation of effectiveness.<br>-3/13 progress not entered at 5:47 p.m., 3/14 progress note entered at 5:39 p.m., and 3/15 progress note entered at 6:30 p.m. all indicated a dose was given for behaviors. The medical lacked documentation of target behaviors, times of medication administration, evaluations for effectiveness and non-pharmacological interventions attempted or offered prior to the administration of the medication.<br><br>The facility failed to identify specific (target) behaviors associated with symptoms of paranoia and agitation after the consultant pharmacist recommended the need for identification of target behaviors and failed to immediately identify non-pharmacological interventions in order to justify the administration of as needed doses. In addition, the facility failed to ensure complete documentation of behaviors, failed to ensure a nurse assessed R88's behaviors prior to and after administration of as needed doses administered by TMA, and failed to document non-pharmacological interventions attempted prior to the administration of as needed doses. | F 329 | | |

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| F 329 | Continued From page 97<br>On 3/21/17, at 8:32 a.m. R88 was observed seated at the dining room table sobbing (but was not tearful) intermittently. NA-L sat next to him. NA-L explained R88 was not doing well because he thought his wife was dead which she was not. NA-L asked R88 if he wanted to talk about it, R88 responded by stating he wanted to go out to the woods to pray. R88 was asked what his favorite prayer was and stopped sobbing and stated he was Christian and his favorite prayer was Come Lord Jesus.<br>-at 9:16 a.m. R88 was seated in the TV viewing area in his wheelchair crying repeatedly help me doctor, help me doctor! An unidentified staff member walked by and stated the doctor was not in today and walked away. R88 resumed calling out for his doctor.<br>-At 9:19 a.m. unidentified staff member repositioned R88 in his wheelchair and informed the resident he was going to therapy and assisted him to therapy<br>R88's medical record on 3/21 did not reflect evidence of the expressed behaviors the facility had identified as target behaviors.<br><br>On 3/22/17, at 7:52 a.m. licensed practical nurse (LPN)-D entered the room with R88's medications. R88 stated leave me alone, LPN-D explained she had medications and he needed to sit up. When TMA-B and LPN-D attempted to assist R88 to sit on the side of the bed, R88 exclaimed ouch a couple of times and cried just leave me alone. LPN-D explained to R88 she had his pain pills and he needed to sit up. When R88 was seated on the edge of the bed as LPN-D attempted to administer medications, R88 stated my bottom hurts. R88 continued to be verbally resistive, however cooperative. LPN-D indicated | F 329 | | |

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| F 329 | Continued From page 98<br>she would administer the rest of the medication after he was up and dressed and directed TMA-B to complete cares. LPN-D exited the room. As TMA-B washed and dressed R88, R88 stated leave me alone just leave me alone, get out of here. After each time R88 made the statements, TMA-B gave encouragement quietly and calmly, explained what she was doing, used distraction with other topics, and tried to engage R88 in conversation. Although R88 was verbally resistive, he was cooperative.<br><br>R88's Behavior/Mood flow sheet for 3/22, written following the above observations indicated merely read "behaviors during cares" and did not specify what the behavior was. The flow sheet indicated the behaviors occurred at 7 a.m. and all interventions were attempted. The documentation indicated the response to the interventions was resistive at first, but after 2-3 attempts behavior/mood stopped.<br><br>On 3/23/17, at 8:39 a.m. R88 was observed seated in his wheelchair in the lobby area. R88 cried out repeatedly, "oh God please help me, God please help me I have to go potty, I have to poop!" Surveyor immediately communicated to facility staff R88 had to use the restroom. R88 continued to yell out and became increasingly agitated and fidgety until he was assisted to the bathroom at 8:44 a.m. by NA-H.<br><br>R88's medical record on 3/23/17 did not reflect documentation of the observed behaviors the facility had identified as target behaviors. | F 329 | | |

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| F 329 | Continued From page 99<br>On 3/21/17, at 2:13 p.m. NA-I stated R88 was very expressive, yelled out "help me, help me" all the time, doesn't know what he needed or wants, and yelled out every day all day. NA-I reported R88 was much better since return from the behavior unit. Staff utilized redirection when he displayed behaviors and most of the time was easily redirectable.<br><br>-At 2:15 p.m. NA-J reported R88 yelled out all day every day and staff would attempt as many interventions as we could. NA-J stated R88's behaviors were better since he returned from the behavioral unit.<br><br>-At 3:28 p.m. NA-K stated R88 got anxious and yelled out, indicated R88 displayed more behaviors when he was not busy doing something.<br><br>On 3/23/17, at 8:38 a.m. TMA-B indicated when a resident asked for an as needed medication, she needed to figure out what it was for and check to see when the last as needed medication was administered. TMA-B stated after the medication was given she would go back to see if it was effective. TMA-B stated she could not administer narcotic medication as a nurse was required to give it. When asked when she would administer R88's Seroquel, TMA-B stated if he was agitated, yelling, screaming, and hitting staff. TMA-B indicated she would administer Trazodone for hard time sleeping or if agitated and trying to get out of bed. TMA-B stated she would administer Neurontin based on facial expression, if he was having pain, and if he was agitated. In response to the question, "How do you know when to administer Seroquel and when to administer | F 329 | | |

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| F 329 | Continued From page 100<br>Neurontin?" TMA-B stated it depended on how anxious he R88 was and if he was really anxious she would administer the Seroquel. TMA-B stated it was hard to tell exactly what's going on with R88 but if she had any questions on what to administer, she would ask a nurse.<br><br>-At 9:24 a.m. the director of nursing (DON) indicated she was not aware the TMA's were administering as needed medications without a nurse assessment and stated the TMA's were not allowed to determine if as needed medications should be given. The DON confirmed as needed medications required a nurse assessment in order to determine if the medication was appropriate for use, and if the medication was administered, the nurse was to go back and assess the effectiveness of the medication. The DON immediately provided education to the TMA's pertaining to the administration of as needed medications. The DON stated she would administer Neurontin if R88's behaviors of agitation and anxiety manifested by pain and she would administer Seroquel for when R88 displayed agitation and anxiety manifested by delusions or hallucinations. The DON indicated the target behaviors in which to administer the medications were not clear. The DON stated behavior documentation should include what the specific behavior was, non-pharmacological interventions attempted and what the response to those intervention were, and effectiveness of the medication, if it had to be administered. The DON verified Trazodone was not administered appropriately and stated R88's physician's orders should have been followed and documentation should have been completed related to non-pharmacological interventions attempted and | F 329 | | |

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| F 329 | Continued From page 101<br>response to those interventions as well as the effectiveness of the medication, if administered. The DON indicated there have been non-pharmacological interventions in the care plan for sleep and for pain. The documentation of pain should include location of pain, intensity, non-pharmacological interventions and response to them and effectiveness of the as needed pain medication if administered.<br><br>Facility Psychotropic Medication Monitoring policy reviewed April 2015, indicated was to assure psychopharmacological drug therapy was effective and necessary to treat a specific condition that quality of life was enhanced for those residents on these medication. The policy directed staff to fill out a monthly behavior monitoring sheet each time the identified behavior occurred so the doctor could review the frequency of the behaviors and what approaches were beneficial. The policy indicated orders for as needed medication would be given for specific, clearly documented circumstances and specific behaviors and interventions would be listed for as needed psychotropic medications. The policy directed nursing to monitor the residents for presence of target behaviors on a daily basis charting by exception (when behaviors are present) and nursing would care plan the resident's specific target behaviors and effective non-pharmacological interventions as well as attach them to the medication on the MAR. | F 329 | | |
| F 425 SS=D | 483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures | F 425 | **F 425**<br><br>Resident 15's medication order was revised to include direction to have the resident rinse his/her mouth | |

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| F 425 | Continued From page 102<br>that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure a mouth rinse was provided after the administration of a steroidal metered dose inhaler medication in order to prevent oral thrush, as directed by the medication's manufacturer recommendations for 1 of 1 resident (R15) observed to receive the medication without the provision of an oral rinse following the medication administration.<br><br>Findings include:<br><br>R15's Physician Order report dated 2/22/17-3/22/17, included an order for Advair Diskus (combination steroid/bronchodilator) 250-50 micrograms (mcg)/dose: 1 puff inhalation twice a day for chronic obstructive pulmonary disease.<br><br>On 3/22/17, at 9:05 a.m. licensed practical nurse (LPN)-A was observed to hand an unlabeled Advair Diskus inhaler to R15. R15 administered a puff and inhaled the medication. LPN-A handed R15 a plastic cup containing UTI Stat (nutrient for | F 425 | after administration of the Advair discus.<br><br>All residents receiving Advair discus and other steroid inhalers will have their medication orders reviewed and revised prior to 5/2/17 to include the direction to rinse their mouth after administration of this medication.<br><br>Education will be provided to all TMAs, LPNs, and RNs prior to 5/2/17 regarding the importance of offering a mouth rinse after the administration of these medications.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure mouth rinses are being offered after the administration of these medications. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 425 | Continued From page 103<br>urinary tract health) 30 milliliters (ml) and water and directed R15 to take a drink. R15 was observed to take two sips and swallow the fluid. LPN-A did not offer or suggest R15 swish/rinse the mouth.<br><br>On 3/22/17, at 9:11 a.m. the manufacturer's Medication Guide and Instructions for use in the Advair Diskus packaging was reviewed with LPN-A. The Medication Guide and Instructions for Use directed the user to rinse mouth with water without swallowing/spit after using Advair Diskus to help reduce the chance of getting oral thrush (a fungal infection). LPN-A confirmed she had not offered or provided R15 a mouth rinse after the use of the medication.<br><br>On 3/23/17, at 2:05 p.m. the director of nursing (DON) confirmed a mouth rinse should have been offered as recommended by the manufacturer after the use of the Advair Diskus medication.<br><br>The Medication Administration-General Guidelines policy revised April 2014, indicated medications are administered as prescribed in accordance with good nursing principles and practices. | F 425 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit | F 431 | **F 431**<br><br>Resident 15's Advair discus is labeled appropriately. | |

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| F 431 | Continued From page 104<br>unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(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.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>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.<br><br>(h) Storage of Drugs and Biologicals.<br>(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.<br><br>(2) The facility must provide separately locked, | F 431 | The medications in the zip lock bag were labeled and disposed of according to facility policy.<br><br>All medication rooms and medication carts will be audited prior to 5/2/17 to ensure all medications are labeled appropriately.<br><br>Education will be provided to all TMAs, LPNs, and RNs to ensure all medications are labeled according to facility policy.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure medications are properly labeled in the medication carts and medication rooms. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 431 | Continued From page 105<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to assure the appropriate prescription labels with directions for use were on an inhalant medication for 1 of 1 resident (R15) whose inhalant medication was observed during medication administration. In addition, the facility failed to ensure 1 of 3 medication rooms medications stored for destruction were properly labeled.<br><br>Findings include<br><br>R15's Physician Order report dated 2/22/17-3/22/17, included an order for Advair Diskus (combination steroid/bronchodilator) 250-50 micrograms (mcg)/dose: 1 puff inhalation twice a day for chronic obstructive pulmonary disease.<br><br>On 3/22/17, at 9:05 a.m. licensed practical nurse (LPN)-A was observed to hand an unlabeled Advair Diskus inhaler to R15. R15 administered a puff and inhaled the medication. LPN-A handed R15 a plastic cup containing UTI Stat (nutrient for urinary tract health) 30 milliliters (ml) and water | F 431 | | |

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| F 431 | Continued From page 106<br>and directed R15 to take a drink. R15 was observed to take two sips and swallow the fluid. LPN-A did not offer or suggest R15 swish/rinse the mouth.<br><br>On 3/22/17, at 9:11 a.m. the manufacturer's Medication Guide and Instructions for use in the Advair Diskus packaging was reviewed with LPN-A. The Medication Guide and Instructions for Use directed the user to rinse mouth with water without swallowing/spit after using Advair Diskus to help reduce the chance of getting oral thrush (a fungal infection). LPN-A confirmed she had not offered or provided R15 a mouth rinse/spit after the use of the medication. LPN-A confirmed the Advair Diskus lacked a prescription label and directions for use. LPN-A stated the Advair Diskus came in a manufacturer's package, which was in a Ziploc bag containing the prescription label. The Ziploc bag was in the manufacturer's boxed package which also contained the prescription label and the directions for use. LPN-A stated staff threw the packaging away and just keep the inhaler. LPN-A stated if the packaging was available the directions for use would have prevented me from providing a drink versus rinse/spit.<br><br>-at 9:27 a.m. registered nurse (RN)-A confirmed the Advair Diskus prescription label with instruction for use should have been on the inhaler or the Advair Diskus should have been stored in the prescription labeled packaging. RN-A confirmed she revised the medication administration record directing staff to provide rinse and spit according to manufactures directions. | F 431 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245397 | A. BUILDING _____ B. WING _____ | 03/23/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVENWOOD CARE CENTER | 1633 DELTON AVENUE BEMIDJI, MN 56601 |

| (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 |
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| F 431 | Continued From page 107<br><br>On 3/23/2017, at 1:30 p.m. during tour of the medication storage room on the secured unit with RN-B. A clear plastic specimen Ziploc bag was observed in the medication destruction bin. RN-B confirmed the Ziploc bag contained approximately 100 round pink tablets and 87 white scored tablets following counting. RN-B confirmed there were no identifiable information on the medications and stated she did not know what the medications were, who they were for, or why they were in the destruction bin. RN-B confirmed medications were left in containers or cards they came in until the nurse responsible for medication destruction completed the task.<br><br>On 3/23/17, at 2:05 p.m. the director of nursing (DON) confirmed a prescription label with indications for use should be on or with all medications and medications for destruction should be in appropriately labeled containers until destruction. The DON confirmed the facility medication destruction program required revision.<br><br>The Pharmacy Services Medication Labels policy, revised 6/2015, indicated medications were labeled in accordance with facility requirements and state and federal laws.<br><br>The Med (medication) Destruction policy, reviewed 4/2015, indicated the LPN'S would destroy medications (other than scheduled narcotic) that could not be returned to pharmacy via our incinerating program. Located on each wing in the medication room would be a gallon size container for pills and for cream/inhalers. | F 431 | | |

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| F 431 | Continued From page 108<br>The nurses would log these medications on the med destruction sheet and would place the meds in the containers. Once these containers were full, pharmacy would remove them and they would be incinerated per their protocol. | F 431 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions | F 441 | **F 441**<br><br>NA-D and NA-E were educated regarding proper hand hygiene.<br><br>The facility's perineal care policy was reviewed and revised on 4/21/17.<br><br>The facilities infection control manual was reviewed on 4/25/17.<br><br>All nursing staff members will be educated prior to 5/2/17 regarding the peri-care policy update.<br><br>Random audits will be completed by the Director of Nursing or designee weekly x 4 weeks to ensure hand washing is being completed appropriately during peri-care. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.<br><br>The Director of Nursing is responsible for this regulation.<br><br>Completion Date: 5/2/17 | |

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| F 441 | Continued From page 109<br>to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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<br><br>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use was provided for 1 of 1 resident (R15) observed during the provision of cares. | F 441 | | |

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| F 441 | Continued From page 110<br><br>Findings include:<br><br>On 3/21/17, at 2:15 p.m. nursing assistant (NA)-E and NA-D were observed to transfer R15 to her bed to provide incontinence cares. NA-E obtained a clean brief, perineal cleansing wipes and a tube of lanoseptic barrier cream. Both NA's washed hands and applied gloves. NA-E removed tape from R15's brief and lowered the brief. The brief was observed saturated with yellow urine. NA-E used both gloved hands to turn and removing the wet brief from under R15. R15's perineal skin was wet with urine and also had red scratch marks and a tegaderm dressing on the right buttock.<br><br>-2:17 p.m. NA-E obtained a cleansing wipe, and wiped R15's buttocks area, turning the wipe over several times to wipe the area. NA-E picked up the barrier cream with her right gloved hand and applied the barrier cream to her soiled left gloved hand and applied the cream to R15's buttock area. NA-E removed her soiled left glove and tossed it in the trash. NA-E and NA-D positioned R15 onto her back. R15 was noted to have scratched her periarea at this time. NA-E obtained cleansing wipes and proceeded to wipe R15's periarea. NA-E picked up the lanoseptic barrier cream with her left hand and applied the barrier cream to R15's front periarea. NA-E removed right soiled glove and with assistance from NA-D, applied R15's clean brief, adjusted her clothing and transferred R15 back into her wheelchair. NA-E was not observed to change her gloves during the pericare and application of | F 441 | | |

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| F 441 | Continued From page 111<br>creams using soiled gloves. NA-D was not observed to provide assistance with cleansing or application of barrier cream. R15 was not observed to be offered or provided hand washing following scratching her periarea.<br><br>On 3/21/17, at 2:38 p.m. NA-E verified R15 was incontinent of urine, frequently scratched her skin including the periarea. NA-E stated R15 scratched her skin frequently resulting in open areas. NA-E confirmed the red areas on R15's peri area was from scratching and the tegaderm on the right buttock covered an open area from scratching.<br><br>On 03/21/2017, at 2:42 p.m. registered nurse (RN)-A verfied soiled gloves should have been removed and hands washed and clean gloves reapplied prior to applying barrier cream.<br><br>The facility undated, Application of Ointment, direct staff to wash hands, open the jar or tube, apply gloves, apply ointment, remove gloves and wash hands.<br><br>The facility Perineal Care Procedure policy, review date 4/2015, lacked direction for applying a perineal/barrier cream during perineal cares. | F 441 | | |

**Havenwood Care Center**

**Addendum to PoC**

**F 282**

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure residents are receiving turning and repositioning per their care plan. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

**F 309**

Resident 69's pacemaker transmission was completed on 3/22/17 and was successful. His next check will be completed at the clinic in Bemidji on July 3rd, 2017. Resident 69 will be discharging from the facility 4/30/17 but this information will be included on his discharge paperwork.

An audit will be developed and implemented prior to 5/2/17 to ensure resident pacemaker checks are completed timely. These audits will be completed 3 times weekly x 4 weeks by the DON or designee to ensure pacemaker checks are being completed timely. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

**F 312**

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure residents are receiving incontinent care per their care plan. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

**F 314**

Random turning and repositioning audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure residents are receiving incontinent care and turning and repositioning per their care plan. Random audits will be completed by the DON or designee weekly x 4 weeks to ensure resident's care plans are comprehensive and are revised appropriately. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

**F 323**

After reviewing resident 88's falls, the facility identified his/her anxiety, restlessness, and difficulty sleeping as causative factors. This resident's anxiety, restlessness, and difficulty sleeping have improved with medication adjustments. His interventions were reviewed for effectiveness and were found to be appropriate.

After reviewing resident 64's falls, the facility identified his/her difficulty sleeping and a correlation that he/she seems to be falling after he/she is being assisted to the bathroom as causative factors related to his/her falls. A sleep study and three day bowel and bladder tracking were initiated on 4/27/17 to assess for sleeping patterns as well as anxiety and restlessness after toileting needs have been met.

The new interventions implemented for resident 64 include an alarming lap belt on her w/c to alert us when she is attempting to get up. A large recliner was placed in the TV area with dycem underneath to prevent sliding. The recliner was added to make her more comfortable when she is sleeping since she prefers to sleep in a recliner. We also felt it would reduce anxiety and restlessness. A video monitor was also added in the TV area to help monitor the resident if she is sitting in the recliner.

A meeting is scheduled to be held on 4/28/17 with her primary care physician for further discussion regarding her fall history.

Occupation and physical therapy will evaluate the resident on 4/28/17.

Prosthetic laboratory will be here on 5/2/17 to measure this resident for a protective helmet.

Audits will be completed by the DON or designee after every fall x 4 weeks to ensure all resident falls are assessed for causative factors, that an intervention is implemented after each fall, and that interventions are assessed for their effectiveness. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

**F329**

Random audits will be completed by the DON or designee 3 times weekly x 4 weeks to ensure care plans are updated when changes occur. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

**F 425**

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure mouth rinses are being offered after the administration of these medications. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

**F 441**

Random audits will be completed on varying shifts 3 times weekly x 4 weeks by the DON or designee to ensure hand washing is being completed appropriately during peri-care. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

Brandan Bjerke. Administrator 4/27/17

**Havenwood Care Center**

**Addendum to PoC**

**F309**

A Pacemaker Care policy was created on 4/24/2017.

**F323**

A restraint assessment was completed for the use of an alarming lap belt for resident 64. The resident cannot release the lap belt on command.

A video monitoring policy was created on 4/26/2017. Notification of use of this video monitoring device has been provided to residents and/or responsible parties. The use of this device has been evaluated and it has been determined that the purpose of this device is to assist in identifying resident safety concerns due to limited visibility of this public lounge area. This device is not recording activity it is only providing staff with real time video monitoring of a public lounge area in our facility.

R64s MD feels the use of a protective helmet is medically necessary.

**F329**

Random audits will be completed by the DON or designee three times weekly x 4 weeks to ensure MD orders are followed, to identify and differentiate target behaviors for administration of prn medications, to ensure resident specific target behaviors and non-pharmacological interventions are identified for each resident, to ensure documentation is completed of non-pharmacological interventions attempted prior to administering a prn medication, and to ensure a nurse is assessing both the need/effectiveness of a prn medication. The results of these audits will be reported to the QAPI Committee. The QAPI Committee will determine further auditing needs.

Brandon Bjerke, Administrator 4-28-17

**Havenwood Care Center**

**Addendum to PoC**

**F323**

The facility will be removing all language relating to the use of a video monitoring device from this PoC.

Brandon Bjerke, Administrator 5-1-17

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

F5397026

PRINTED: 04/12/2017
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245397 | A. BUILDING **01 - NURSING HOME** B. WING _____ | 03/22/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **HAVENWOOD CARE CENTER** | **1633 DELTON AVENUE BEMIDJI, MN 56601** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Havenwood Care Center 01 Main Building 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 and the 2012 edition of NFPA 99, Health Care Facilities Code.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101 | K 000 | **APPROVED** Thomas Linhoff<br>**By Tom Linhoff at 3:18 pm, Apr 26, 2017** | |

RECEIVED
APR 26 2017
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Brendan Bjerke | Administrator | 4-26-17 |

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

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| K 000 | Continued From page 1<br>Or by e-mail to:<br>Marian.Whitney@state.mn.us<br>and<br>Angela.kappenman@ state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency<br><br>Havenwood Care Center was built in 4 stages. The 1968 original building is 1- story, without a basement and was determined to be Type II (111) construction. In 1971 an addition to the south of the original building was built, is 1-story with a partial basement and was determined to be of a Type II (222) construction. The 1974 addition was built to the south of the 1971 addition, is 1-story without a basement and was determined to be of Type II (111) construction. In 1992 additions were built to the west of the 1968 building and east of the 1971 building. They are separated with 2-hour fire barriers and determined to be Type II(111) construction.<br><br>The building is completely protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has | K 000 | | |

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| K 000 | Continued From page 2<br>a fire alarm system that includes corridor smoke detection, with additional detection in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system has automatic notification of the local fire department.<br><br>The facility has a capacity of 90 beds and had a census of 74 at the time of the survey.<br><br>Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building.<br><br>The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 363 SS=F | NFPA 101 Corridor - Doors<br><br>Corridor - Doors<br>2012 EXISTING<br>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or | K 363 | **K363**<br><br>**Gaps identified between the doors and the door frames on resident room doors 29,49, and 69 were filled with Poron Flame Retardant Cellular Urethane Foam Gasket Tape on 4/26/17.**<br><br>**New doors for resident rooms 29, 49, and 69 have been ordered. They have not yet been delivered.**<br><br>**The Director of Environmental Services has audited all resident room doors to check for appropriate fit of door and door frame.** | |

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| K 363 | Continued From page 3<br>pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.<br>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.<br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview the facility failed to provide three corridor doors with a means suitable to resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 39 of the 74 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 07:30 am to 12:30 pm on 03/22/2017 observations and staff interview revealed the following resident room doors did not fit tight in the frame, 29, 49, 69.<br><br>This deficient condition was confirmed by the Facility Administrator and the Director of Maintenance. | K 363 | **This audit will be completed monthly for three months and results of this audit will be reported at our QAPI Committee meetings. The QAPI Committee will determine further auditing needs.**<br><br>**The Director of Environmental Services is responsible for compliance with this regulation.**<br><br>**Completion Date 4/26/17.** | |

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 5842

April 10, 2017

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, Minnesota 56601

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5397027

Dear Mr. Bjerke:

The above facility was surveyed on March 20, 2017 through March 23, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the correction orders cited herein are not corrected, a civil fine for each correction order not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at the phone number or email mentioned above.

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

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

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

Sincerely,

Mark Meath

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

Enclosure(s)

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 |
|---|---|---|---|
| | 00017 | A. BUILDING: _____ B. WING _____ | 03/23/2017 |

RECEIVED APR 26 2017 Minnesota Department of Health Bemidji

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAVENWOOD CARE CENTER | 1633 DELTON AVENUE BEMIDJI, MN 56601 |

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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at | 2 000<br><br>4/27/17 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. | |

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

Brandon Byerke — Administrator — 4-26-17



Corrected 5/2/17 Brandon Byerke

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at | 2 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. | |

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| 2 000 | Continued From page 1<br><http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>On March 20, 21, 22, 23, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. | 2 000 | The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |

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| 2 000 | Continued From page 2<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 560 | MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents<br><br>Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to develop a care plan related to the identified risk/goals for pressure ulcers in order to prevent the risk for the development for pressure ulcers and failed to develop a care plan which included a goal and non-pharmacological interventions to be implemented for 1 of 4 residents (R88) reviewed for pressure ulcers and hypnotic medication use. In addition, based on observation, interview, and document review the facility failed develop a care | 2 560 | | |

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| 2 560 | Continued From page 3<br>plan for a cardiac pacemaker which included goals and medical management interventions for 1 of 1 resident (R69) reviewed who had a pacemaker.<br><br>Finding included:<br><br>R88 was at risk for pressure related ulcers and received medication to induce sleep for a diagnosed sleep disorder and a care plan was not developed to identify these areas.<br><br>R88's undated Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, obstructive sleep apnea, myelodysplastic syndrome (a blood cancer), and anxiety disorder.<br><br>R88's admission Minimum Data Set (MDS) dated 12/18/16, indicated R88 had severe cognitive impairment, required extensive assistance from one to two staff for activities of daily living, had balance impairment and had functional limitations in range of motion in one upper extremity. The MDS further indicated R69 was frequently incontinent of urine, did not have a pressure ulcer upon admission, was at risk for pressure ulcers, and had a turning and repositioning program. The 14 day Medicare MDS dated 12/25/16, indicated R69 had trouble falling asleep, staying asleep, or sleeping too much.<br><br>Physician's orders included, Trazodone 50 milligrams by mouth at bedtime, and may give one additional dose as needed after the | 2 560 | | |

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| 2 560 | Continued From page 4<br>scheduled bedtime dose prior to 3:00 a.m.<br><br>R88's pressure ulcer CAA dated 12/18/16 indicated R88 was at risk for pressure ulcers related to urinary incontinence, and impaired mobility that required extensive assistance from staff, cognitive loss, functional limitation in range of motion, diagnosis of dementia, pain, weakness, fracture of clavicle, and poor nutrition. The CAA indicated R69 required a regular schedule of turning and staff would turn and reposition every two hours while in bed. The CAA indicated a care plan would be developed and R88 would have intact skin and continue to reposition as scheduled.<br><br>R88's current care plan dated 12/28/16, did not identify R88 was at risk for pressure ulcers and lacked a goal for preventing or decreasing the risk of obtaining a pressure ulcer. The care plan indicated R88 had alteration in elimination and was incontinent more than seven times per week and directed staff to provide extensive assist of two staff to transfer on and off toilet every two hours, staff check with toileting and change as needed, and provide peri rectal care after elimination. The care plan also indicated R88 had decreased physical mobility with potential for falls and directed staff to provide extensive assist of one to turn and reposition every two hours. The care plan identified R88 was at risk for dehydration and directed staff to monitor skin for hydration, redness, and breakdown. The care plan lacked a care plan for sleep which would include goals, medication management of Trazodone (medication to induce sleep) and non-pharmacological interventions to be attempted prior to the administration of the | 2 560 | | |

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| 2 560 | Continued From page 5<br>Trazadone.<br><br>On 3/23/17, at 2:43 p.m. registered nurse (RN)-E confirmed a specific care plan was not developed nor was an assessed goal identified for pressure ulcers, however, stated the interventions to reduce the risk for pressure ulcers were added to the problem statement that was causing the risk. RN-E stated a specific care plan for pressure ulcers would be developed if there was an actual pressure ulcer or history of pressure ulcers.<br><br>-At 4:27 p.m. the director of nursing (DON) confirmed there should have been a care plan developed for pressure ulcers and for sleep.<br><br>R69 had a pacemaker which was not identified on the care plan.<br><br>R69's admission MDS dated 1/20/17 included diagnoses of atrial fibrillation, heart failure, hypertension, and history of stroke. The MDS indicated R69 had moderate cognitive impairment and required extensive assistance from staff to complete activities of daily living. R69's undated Face Sheet indicated R69 had a diagnosis of old myocardial infarction (heart attack). R69's hospital Discharge Summary dated 1/20/17, indicated R69 had a pacemaker.<br><br>R69's care plan dated 2/8/17 identified diagnosis of atrial fibrillation and stroke, however did not identify the presence of R69's pacemaker.<br><br>On 3/20/17, at 7:22 p.m. a pacemaker monitor was observed on R69's nightstand. R69 | 2 560 | | |

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| 2 560 | Continued From page 6<br>explained the purpose of the monitor was so the pacemaker clinic could continuously monitor the functionality of the pacemaker and monitor for abnormal heart rhythms. R69 stated he was supposed to have his pacemaker checked every three months.<br><br>On 3/22/17, at 7:09 a.m. licensed practical nurse (LPN)-D stated was not sure where to find information pertaining to R69's pacemaker, was not sure what arrhythmia the pacemaker was set to correct, and did not know R69's pulse parameters. LPN-D stated the registered nurses (RN) obtained information pertaining to pacemakers and would develop the care plan.<br><br>-At 10:51 a.m., pacemaker clinic registered nurse (RN)-F indicated R69's pacemaker was for bradycardia (slow heart rate), was not a defibrillator, the low end setting was 70 beats per minute, RN-F explained if R69's pulse should go under 70 beats for a full minute, it was a concern, and the staff at the facility would need to call the pacemaker clinic to ensure pacer was functioning appropriately. RN-F stated the pacemaker clinic expected facility staff to have knowledge of pacemaker settings, when to contact the clinic, and of recommended pacemaker checks.<br><br>-At 11:00 a.m., the DON indicated there should have been a care plan developed for the pacemaker.<br><br>-At 12:27 p.m., RN-E stated she did not know why R69 had a pacemaker and thought the care plan included the pacemaker, and was not aware if the pacemaker should have been on the care plan. | 2 560 | | |

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| 2 560 | Continued From page 7<br><br>Facility policy Resident Care Planning last reviewed 4/2015 included: Planning Objectives and Rationale 1. to promote optimal resident independence and quality of care by focusing and directing staff efforts to individuals, 2. To promote appropriate utilization and coordination of services and avoid duplication and wasted efforts, 7. To meet accountability requirements for fiscal intermediaries. The policy lacked direction and/or requirements for the care plan content.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing or designee could review/ revise policies and procedures related to care plan development and provide education to staff to address the importance of developing a comprehensive care plan to meet each resident's needs. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-one (21) days. | 2 560 | | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.<br><br>This MN Requirement is not met as evidenced | 2 565 | | |

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| 2 565 | Continued From page 8<br>by:<br>Based on observation, interview and document review, the facility failed to provide turning and repositioning assistance and/or incontinence cares as directed by the care plan 2 of 2 residents (R15, R89) who required assist with repositioning and incontinence cares. In addition, the facility failed to ensure the placement of Prevalon pressure reduction boots as directed by the care plan for 1 of 2 (R89) residents at risk for heel breakdown.<br><br>Findings include:<br><br>R15 was at risk for pressure ulcers and was incontinent and did not receive timely turning and repositioning and incontinence care as directed by the care plan.<br><br>R15's Care Plan dated 1/18/17, indicated R15 had decreased physical mobility, bilateral lower extremity amputation with inability to transfer, turn/reposition or site up/lie down per self. R15 required two staff extensive assist for turning and repositioning every hour. R15 was unable to complete personal hygiene independently and had bowel and bladder incontinence. The plan indicated R15 required extensive assistance of two staff to check and change R15's incontinent product and provide cleansing after elimination every two hours.<br><br>The untitled and undated nursing assistant worksheets indicated R15 required turning and repositioning assistance every hour and toileting/incontinent checks every two hours. | 2 565 | | |

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| 2 565 | Continued From page 9<br><br>On 3/22/17, during continuous observations from 7:15 a.m. to 11:00 a.m. R15 was observed to remain seated in her wheelchair without receiving assistance.<br>-At 7:45 a.m. R15 was observed to propel her wheelchair to the dining room for breakfast and returned to her room.<br>-At 9:04 a.m. licensed practical nurse (LPN)-A entered R15's room to administer medication. LPN-A did not offer nor provide R15 repositioning or toileting assistance.<br>-At 9:53 a.m. R15's call light was observed on.<br>-At 9:58 a.m. nursing assistant (NA)-C was entered R15's room, turned the call light off and immediately exited the room.<br>-At 10:00 a.m. R15 stated she had told the NA she needed her incontinent product changed and the NA stated she would be back to help her because she was busy with another resident.<br>-At 10:18 a.m. NA-C returned to R15's room and proceeded to assist R15's roommate.<br>-At 10:35 a.m. NA-C began to assist R15. R15 asked her what she was doing and NA-C informed R15 she was going lay her down. R15 stated she did not want to lie down. NA-C stopped assisting R15 and stated R15 refused a lot. When asked by the surveyor if she would lay down so staff could change her incontinent product, R15 stated that was why I turned the call light on in the first place.<br>-At 10:45 a.m. NA-C proceeded to provide R15 incontinent cares. When removed, the incontinent product was observed to be extremely saturated with urine. NA-C confirmed the brief was saturated. NA-C proceeded to cleanse R15's peri area with wipes. R15 asked NA-C stated are you doing, NA-C stated she needed to cleanse R15 well due to R15's peri area scratches. Upon | 2 565 | | |

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| 2 565 | Continued From page 10 | 2 565 | | |

completing the peri care, NA-C stated she needed to get the nurse and would be right back. NA-C returned to the room with LPN-A who applied a tegaderm dressing to R15's right buttock covering an open area. LPN-A informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 centimeters (CM) by 0.50 cm. LPN-A stated R15 frequently scratched her body including her peri area resulting in open areas and scratch marks. LPN-A stated she applied the dressing to help prevent infections. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently falls off.
-At 10:58 a.m. R15's cares were completed. NA-C confirmed R15's brief was very saturated with urine and her skin was wet. NA-C stated she had not provided R15 with turning and repositioning and incontinence cares until just now.
-At 10:59 a.m. NA-B entered R15's room. NA-B stated she had assisted R15 up at 7:00 a.m. and pointed to a white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B verified 7:00 a.m. was noted on the board. NA-B confirmed she had not provided incontinence care or repositioning assistance to R15 since 7:00 a.m. (three hours and 30 minutes earlier). NA-B referred to the nursing assistant work sheet which she removed from her pocket and verified R15 was to be repositioned every hour and incontinent product checked and changed every two hours. NA-B stated even though R15 could tell us she needed help, it was staff's responsibility to provide the cares without R15 having to ask us.

On 3/22/17, at 11:10 a.m. the director of nursing

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| 2 565 | Continued From page 11<br>(DON) confirmed R15 should have been repositioned every hour and provided with check and change incontinence care every two hours as directed by the care plan. The DON stated it was her expectation for staff to follow and implement R15's care plan, as written.<br><br>R89 was not provided every one hour repositioning during two observations and Prevalon boots (heel offloading device/boots) were not provided for 1 hour 30 minutes on 3/22/17, as directed by the Care Plan<br><br>R89's undated Care Plan indicated R89 had potential for alteration in skin integrity related to pressure sore on left heel and directed staff to:<br><br>--turn and reposition every one hour and as needed<br>--provide peri rectal care after each incontinent episode.<br>--monitor for persistent red areas and report to registered nurse (RN)<br>--maintain adequate nutrition and hydration by providing dietary decub [decubitus] program<br>--wound care/dressing change as ordered.<br>--keep skin clean and dry.<br>--APP [alternating pressure pad] mattress on bed.<br>--pressure relief boots on both feet as ordered.<br><br>R89's Physician Order Report dated 2/23/17-3/23/17, included an order to wear Prevalon (blue) heel lift boots at all times except for bathing. Ensure heel is in proper position.<br><br>On 3/22/17, from 7:03 a.m. until 8:28 a.m. (1 hour | 2 565 | | |

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| 2 565 | Continued From page 12<br>25 minutes) R89 was continuously observed sleeping bed, lying on her back with her shoulders positioned slightly to the right. R89 was not repositioned or offered repositioning during this time.<br>-From 9:16 a.m. to 10:47 a.m. R89 was continuously observed in bed, lying on her back without staff entering her room for repositioning.<br>--at 10:47 a.m. R89 was observed awake and watching television while in bed, positioned on her back. R89 stated she liked to sleep in in the morning and no one had come in to get her up for the day yet.<br>--at 10:52 a.m. licensed practical nurse (LPN)-A entered R89's room with a syringe and administered R89's insulin in the abdomen. R89 remained positioned on her back. LPN-A did not offer or provide repositioning assistance.<br>--at 11:26 a.m. (2 hours and 10 minutes later) NA-C stated she had last been in R89's room at 9:15 a.m. at which time she checked R89's incontinence brief and asked R89 if she wanted to get up for the day. NA-C indicated R89's brief had been dry and R89 was not ready to get up. NA-C entered R89's room, gathered a basin of water and proceeded to provide morning cares. When, NA-C uncovered R89, she was observed wearing blue Prevalon boots on both feet. NA-C removed the boots which revealed gauze dressing on the left heel. R89's right heel was intact and without redness. Following the completion of personal cares, NA-C stated R89 was to be repositioned every two hours. NA-C stated it used to be every hour when R89 had an open sore to her heel. NA-C assisted R89 to complete dressing and placed a mechanical lift sling under R89. NA-A entered the room with a mechanical lift and both NAs transferred R89 to the wheelchair. R89's wheelchair was observed equipped with a seat cushion and a padded board | 2 565 | | |

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| 2 565 | Continued From page 13<br>positioned across the calf support area of the wheelchair foot/leg rests. The foot/leg rests were raised slightly less than parallel to the floor. NA-C wheeled R89 out of her room and to the dining room at approximately 12:00 p.m. R89's Prevalon boots were not reapplied.<br><br>On 3/22/2017, at 1:37 p.m. R89 was observed in her room, seated in her wheelchair. LPN-A stated she had just assisted R89 to put on her Prevalon boots. LPN-A verified R89 had not had them on and confirmed she should have them on at all times due to issues with her heels. NA-C asked LPN-A, "Aren't we supposed to release them once in a while?" LPN-A stated the boots should be on at all times.<br><br>On 3/22/17 at 1:40 p.m. NA-C confirmed she had not put R89's Prevalon boots on when she got R89 up for the day and should have done so. NA-C verified the boots were off for approximately one hour and 30 minutes.<br><br>On 3/23/2017, at 9:51 a.m. RN-A confirmed R89 should have been turned and repositioned every one hour and should have worn the Prevalon boots at all times except for bathing, as directed by the care plan.<br><br>A Resident Care Planning Policy and Procedure, reviewed 4/2015, indicated the care plan was to promote optimal resident independence and quality of care by focusing and directing staff efforts to individual needs and to promote appropriated utilization and coordination of | 2 565 | | |

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| 2 565 | Continued From page 14<br>services.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) and/or designee could review or revise policies and provide education for staff regarding care plan implementation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-one (21) days. | 2 565 | | |
| 2 570 | MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision<br><br>Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to revise the care plan to include additional fall prevention interventions following | 2 570 | | |

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| 2 570 | Continued From page 15<br>fall incidents for 1 of 4 residents (R64) reviewed for accidents. In addition, the facility failed to revise the care plan for pain to include non-pharmacological interventions for 1 of 5 residents (R88) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R64's care plan was not revised to include additional fall prevention interventions following fall incidents.<br><br>R64's Face Sheet [undated], indicated R64's diagnoses included Alzheimer's disease, anxiety, dizziness, seizures, depression, obesity, macular degeneration (poor vision) , cataracts, psychosis, delusional disorder and dementia.<br><br>R64's Fall Risk Assessment dated 2/23/17, indicated R64 was at risk for falls. No new fall prevention interventions were identified and staff were directed to continue with the current fall interventions.<br><br>R64 sustained 12 falls between 10/23/16, through 2/9/17. R64's care plan dated 3/16/17, identified a problem area for potential risk for falls and skin integrity. Fall prevention interventions listed included:<br>- provide assist of one staff to ambulate on and off the unit<br>- provide limited assist of one staff to transfer, also transfers self at times<br>- manual tilt and space wheelchair for comfort, | 2 570 | | |

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| 2 570 | Continued From page 16<br>positioning and safety<br>- refer to nursing orders for further fall interventions<br><br>R64's physician orders indicated from 10/23/16, through 2/9/17, the following fall prevention interventions were in place which were not identified on the care plan:<br>- Lavender oil behind the ears for relaxation twice a day (initiated 11/23/15)<br>- Contour mattress with cut out (initiated 12/28/15)<br>- 30 minute checks (initiated 2/19/16)<br><br>On 3/23/17, at 2:15 p.m. the director of nursing (DON) confirmed prior to R64's fall on 3/2/17, the only fall prevention interventions documented on R64's physician orders or R64's care plan were lavender oil behind the ears for relaxation twice a day (initiated 11/23/15); contour mattress with cut out (initiated 12/28/15); and 30 minute checks (initiated 2/19/16).<br><br>Fall Prevention policy dated 4/2015, indicated the facility would identify residents who were at high risk for falls and develop individual fall precautions for those residents. A post fall assessment would be completed after each fall and any changes in interventions would be noted on the form, in the residents nursing orders, alarms would be added to the care plan, and staff assignment sheets.<br><br>R88's care plan was not revised to include non-pharmacological interventions for pain control which could be attempted prior to | 2 570 | | |

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| 2 570 | Continued From page 17<br>administration of an as needed pain medication.<br><br>R88's Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, myelodysplastic syndrome, diverticulitis, and anxiety disorder.<br><br>R88's admission Minimum Data Set (MDS) dated 12/18/16, indicated R88 had severe cognitive impairment, had occasional pain which did not interfere with activities or sleep, had scheduled pain medications, rated pain at a 5 on a 0-10 scale, used as needed pain medications, and non-pharmacological interventions were not used. A Care Area Assessment for pain was not triggered or completed.<br><br>R88's care plan for pain dated 12/28/16, indicated R88 had a potential for alteration in comfort related to a cervical spine fracture, left clavicle fracture and low back pain. The care plan directed staff to medicate as ordered, use a pain scale to assess pain, assist to positron for comfort and to keep physician updated. The care plan lacked non pharmacological interventions to be attempted prior to the use of pain medication.<br><br>R88's physician orders revealed an order for Neurontin solution 250mg/5ml (milliliters) give 50 mg every two hours as needed for pain, anxiety, restlessness. Max of six as needed doses in 24 hours.<br><br>On 03/23/2017, at 4:27 p.m. director of nursing | 2 570 | | |

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| 2 570 | Continued From page 18<br>(DON) indicated the care plan should include non-pharmacological interventions that could attempted prior to administration of an as needed pain medication.<br><br>Facility policy Resident Care Planning Policy and Procedure last reviewed 4/2015, indicated care plans were to be reviewed every 30 days by an RN. If changes in a problem, goal, or approach occurred between scheduled review times the charge nurse and department member involved in the revision must meet informally and revise the care plan.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing or designee could review/ revise policies and procedures related to care plan revision and provide education to staff to address the importance of revising care plans when there has been a change in services. Resident care plans could be reviewed/ revised for compliance. The quality assessment and assurance committee could establish a system to audit care plans to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-one (21) days. | 2 570 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in | 2 830 | | |

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| 2 830 | Continued From page 19<br>the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide ongoing monitoring and coordination of care with a pacemaker clinic to ensure routine pacemaker checks were completed for 1 of 1 resident (R69) reviewed who a had pacemaker without routine checks had conducted.<br><br>Findings included:<br><br>R69's admission Minimum Data Set (MDS) dated 1/20/17, indicated R69 had diagnoses of atrial fibrillation (irregular heart rhythm, often time's rapid heart rate), heart failure, hypertension, and history of stroke. The MDS also indicated R69 had moderate cognitive impairment and required extensive assistance from staff to complete activities of daily living. R69's undated facility Face Sheet also included diagnosis of old myocardial infarction (heart attack). R69's hospital Discharge Summary dated 1/20/17, indicated R69 had a pacemaker.<br><br>R69's Clinical Admission Assessment dated | 2 830 | | |

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| 2 830 | Continued From page 20<br>1/21/17, indicated R69 had a pacemaker and was due for a pacer check sometime this month [January 2017] and while at home, R69 performed these checks wirelessly. The assessment did not include or identify the indication for pacemaker and/or type, pacemaker rate settings, pulse parameters, location, or pacemaker check schedule.<br><br>R69's care plan dated 2/8/17, indicated R69 had diagnoses of atrial fibrillation and stroke, however the plan did not identify the presence of R69's pacemaker.<br><br>R69's Vitals Report was reviewed since admission and revealed R69's pulse was taken on taken on 1/20, 1/21 (4 times), 1/29, 2/1, 3/1, 3/8, and on 3/15/17. The record reflected on 1/20/17, R69's pulse was 68. However, R69's medical record lacked evidence the pacemaker clinic was notified of R69's pulse below the low end setting of 70 beats per minutes as indicated by the pacemaker clinic registered nurse (RN)-F.<br><br>On 3/20/17, at 7:22 p.m. a pacemaker monitor was observed on R69's nightstand. R69 stated the purpose of the monitor was so the pacemaker clinic could continuously monitor the functionality of the pacemaker and to monitor for abnormal heart rhythms. However, R69 stated the monitor had not worked since admission to the facility and was not sure when it was going to get fixed. R69 stated he was supposed to have his pacemaker checked every three months and thought he had missed the last scheduled check. | 2 830 | | |

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| 2 830 | Continued From page 21<br><br>On 3/22/17, at 7:09 a.m. licensed practical nurse (LPN)-D stated was not sure where to find information pertaining to R69's pacemaker and was not sure what arrhythmia the pacemaker was set to correct, and did not know R69's pulse parameters. LPN-D stated the registered nurses (RN) obtained information pertaining to pacemakers and would develop the care plan.<br><br>-At 8:47 a.m. RN-C stated she was aware R69 had a pacemaker, however, was not aware of what arrhythmia the pacemaker was supposed to correct and if there were recommended pulse parameters. RN-C confirmed R69's pacemaker was supposed to be checked sometime in January, however the facility could not get the monitor hooked up due to the lack of correct adapters and the lack of manufacturer's directions which the resident had left at home. RN-C stated when all of the equipment was obtained the pacemaker clinic was called to assist with set-up and to ensure functionality. RN-C stated the pacemaker was checked on 2/27/17, but was not aware of when the next check was to be conducted, however stated it should be every three months.<br><br>-At 10:51 a.m. RN-F stated R69's pacemaker was for bradycardia (slow heart rate), was not a defibrillator and the low end setting was 70 beats per minute. RN-F confirmed R69's last pacemaker check was 10/17/16, and had missed a scheduled check. RN-F stated it would be a concern if R69's pulse should go under 70 beats for a full minute and facility staff would need to call the pacemaker clinic to ensure the pacemaker was functioning properly. RN-F stated if the pacemaker monitor was off line, the pacemaker itself would continue to store information of irregular rhythms until the next | 2 830 | | |

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| 2 830 | Continued From page 22<br>pacemaker check. RN-F stated the pacemaker clinic expected the staff to have knowledge of pacemaker settings, when to contact the clinic, and of recommended pacemaker checks.<br><br>-At 11:00 a.m. the director of nursing (DON) stated there should have been a care plan developed for R69's pacemaker.<br><br>-At 12:27 p.m., RN-E stated she did not know why R69 had a pacemaker, thought the care plan included the pacemaker but was not aware if the pacemaker should be on the care plan or not.<br><br>Facility policy/procedure was requested related to pacemaker care and monitoring and was not received.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures related to assessment and implementation of interventions following a fall and the care and monitoring of pacemakers. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan.<br><br>TIME PERIOD OF CORRECTION: Twenty-one (21) Days. | 2 830 | | |
| 2 840 | MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin<br><br>Subp. 2. Criteria for determining adequate and | 2 840 | | |

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| 2 840 | Continued From page 23<br>proper care. The criteria for determining adequate and proper care include:<br><br>B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence.<br><br>[ 144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan. ]<br><br>Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. | 2 840 | | |

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| 2 840 | Continued From page 24<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely bladder incontinence care as directed by the care plan for 1 of 1 resident (R15) who was incontinent of urine and was not provided timely assistance.<br><br>Findings include:<br><br>R15's quarterly Minimum Data Set (MDS) dated 1/16/17, indicated R15 was cognitively intact and required extensive assistance with transfers and toileting. The MDS further indicated R15 was always incontinent, was at risk for the development of pressure ulcers, had moisture associated skin damage and required application of topical ointments.<br><br>R15's Urinary incontinence Care Area Assessment (CAA) dated 10/23/15, indicated R15 had stress incontinence which occurred with coughing and sneezing, overflow incontinence due to blocked urethra or weak bladder muscles and functional incontinence due to inability to get to the toilet in time due to physical disability. R15's CAA further indicated R15 was always incontinent of urine, required extensive assist with toileting and was at risk for infection, skin rashes/breakdown, and offensive body odor.<br><br>R15's Care Plan dated 1/18/17, indicated R15 was unable to complete personal hygiene independently, had bowel and bladder | 2 840 | | |

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| 2 840 | Continued From page 25<br>incontinence and required two staff extensive assist for toileting needs. The plan directed two staff to check and change R15's incontinent product/brief and provide peri-rectal care every two hours.<br><br>R15's Physician Order Report dated 2/22/17-3/22/17, directed staff to attempt to change brief as soon as it was wet.<br><br>The untitled and undated nursing assistant worksheets, indicated R15 required toileting checks every two hours.<br><br>On 3/22/17, during continuous observations from 7:15 a.m. to 11:00 a.m. (3 hours and 45 minutes) R15 was observed to remain seated in her wheelchair without incontinence cares provided.<br>-At 7:45 a.m. R15 was observed to propel her wheelchair to the dining room for breakfast and returned to her room.<br>-At 9:04 a.m. licensed practical nurse (LPN)-A entered R15's room to administer medication and exited the room. LPN-A did not offer repositioning or toileting assistance to R15.<br>-At 9:53 a.m. R15's call light was observed on.<br>-At 9:58 a.m. nursing assistant (NA)-C was entered R15's room, turned off the call light and immediately exited the room.<br>-At 10:00 a.m. R15 stated, she had told NA-C she needed her incontinent product changed. R15 stated NA-C told her she would be back to help because she was busy with another resident.<br>-At 10:18 a.m. NA-C returned to R15's room and proceeded to assist R15's roommate.<br>-At 10:35 a.m. NA-C began to assist R15. R15 asked NA-C what she was doing and NA-C | 2 840 | | |

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| 2 840 | Continued From page 26 | 2 840 | | |

responded by informed R15 she was going to lay her down. R15 stated she did not want to lay down so NA-C stopped assisting R15. NA-C stated R15 refused cares a lot. When asked by surveyor if she would lay down so her incontinent product could be changed, R15 stated that was why she had turned the light on in the first place.
-At 10:45 a.m. NA-C proceeded to remove R15's incontinent brief. The brief was noted to be heavily saturated with urine. NA-C confirmed the brief was saturated and proceeded to cleanse R15's peri area with cleansing wipes. When cleansing, R15 asked NA-C what she was doing and NA-C responded by stating she needed to clean her well because of R15's scratch marks on her bottom. Upon completing the peri-rectal cares, NA-C retrieved LPN-A. LPN-A applied a Tegaderm dressing to R15's right buttock and informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 centimeters (CM) by 0.50 cm. and stated R15 frequently scratched her body and perineal area resulting in open areas and scratch marks. LPN-A stated she applied the Tegaderm to help prevent infection. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently fell off.
-At 10:58 NA-C confirmed R15's incontinent product was heavily saturated and her skin was wet. NA-C verified she had not provided R15 with incontinent cares prior now.
-At 10:59 a.m. NA-B entered R15's room. NA-B stated she had assisted R15 up at 7:00 a.m. and pointed to the white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B verified 7:00 a.m. was noted on the board. NA-B confirmed she had not provided incontinent cares to R15 since she 7:00 a.m. NA-B also referenced the nursing assistant work sheet and confirmed R15

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| 2 840 | Continued From page 27<br>was to have her incontinent product checked and changed every two hours. NA-B also stated even though R15 could tell us she needed help, it was staff's responsibility to provide the cares without R15 having to ask us.<br><br>On 3/22/17, at 11:10 a.m. the director of nursing (DON) confirmed R15 should have been provided with incontinence care every two hours, as directed by the care plan. The DON stated it was her expectation for staff to follow and implement R15's care plan, as directed.<br><br>A Resident Care Planning Policy and Procedure, reviewed 4/2015, indicated the care plan was to promote optimal resident independence and quality of care by focusing and directing staff efforts to individual needs and to promote appropriated utilization and coordination of services.<br><br>Although requested, no policy related to incontinence care was provided.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, monitor, evaluate to assure residents who are incontinent of urine, receive the necessary services and care following each episode of incontinence.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 2 840 | | |

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| 2 840 | Continued From page 28<br>(21) days. | 2 840 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to prevent the development of two stage 2 pressure ulcers for 1 of 4 residents (R88) who developed two pressure ulcers following admission to the facility. In addition, the facility failed to provide timely repositioning in order to minimize the risk of pressure ulcer development for 2 of 4 residents (R89, R15) identified at risk for pressure ulcers and who required assistance for repositioning.<br><br>Findings included: | 2 900 | | |

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| 2 900 | Continued From page 29<br><br>R88's undated Face Sheet included diagnoses of dementia, fracture of left clavicle and seventh vertebra, myelodysplastic syndrome, and anxiety disorder.<br><br>R88's admission Minimum Data Set (MDS) dated 12/18/16, indicated R88 had severe cognitive impairment, required extensive assistance from two staff for bed mobility and toileting, and required extensive assist from one staff for transferring. The MDS further indicated R88 was frequently incontinent of urine, did not have a pressure ulcer upon admission, was at risk for pressure ulcers and was on a turning and repositioning program.<br><br>R88's Pressure Ulcer Care Area Assessment (CAA) dated 12/18/16, indicated R88 was at risk for pressure ulcers related to urinary incontinence, impaired mobility, cognitive loss, functional limitation in range of motion and diagnoses of dementia, pain, weakness, fracture of clavicle, and poor nutrition. The CAA indicated R69 required a turning schedule and staff would turn and reposition R88 every two hours while in bed. The CAA indicated R88 received no at risk medications, however failed to identify the use of antidepressant, antipsychotics, and narcotic pain medications that could increase the risk for pressure ulcers. The CAA indicated a care plan would be developed related to the risk for pressure related ulcers.<br><br>R88's Braden scale (tool used to help determine the risk for developing pressure ulcers) dated 3/20/17, indicated R88 was at risk for pressure | 2 900 | | |

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| 2 900 | Continued From page 30<br>ulcers.<br><br>R88's Tissue Tolerance Assessment (a tool to determine amount of time skin can tolerate pressure without change) dated 3/20/17, indicated R88 should be repositioned every two hours while in the wheelchair, reclining chair, and bed.<br><br>R88's care plan dated 12/28/16, indicated R88 had decreased physical mobility and directed staff to provide extensive assistance to turn and reposition every two hours, assist to sit up/lie down and get feet and legs into bed. Assist of one to ambulate and transfer. Staff to wheel to all destinations. Monitor for persistent red areas and notify the registered nurse. The care plan did not indicate R88 was at risk for pressure related ulcers. R88 had alteration in elimination, was incontinent and directed staff to provide extensive assist of two to toilet every two hours, check with toileting and change as needed, and provide peri rectal care after elimination. The care plan also indicated R88 was at risk for dehydration and directed staff to monitor R88's skin for hydration, redness and breakdown.<br><br>R88's nursing assistant (NA) care guide directed staff to turn and reposition R88 every two hours.<br><br>R88's quarterly dietary assessment dated 3/13/17, indicated R88 had a significant weight loss of 9% in 30 days, and R88 had an approximately 30 day inpatient behavioral health clinic stay and returned to the facility on 2/2/17. The assessment indicated R88 was able to feed | 2 900 | | |

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| 2 900 | Continued From page 31<br>himself and on 2/3/17, four ounces of dietary supplement was initiated four times a day. R88's recorded weights revealed an admission weight of 124 lbs. (pounds), weight on 2/6/17, 121 lbs. and on 3/21/17, R88 weighed 116 lbs.<br><br>R88's physician orders included Neurontin (pain medication) three times a day and as needed for pain, anxiety and restlessness. Oxycodone, a narcotic, three times a day for low back pain. Tylenol three times a day for low back pain. Trazodone an antidepressant, 50 mg for trouble sleeping. Effexor, an antidepressant, extended release every evening for anxiety disorder and Seroquel three times a day and as needed for paranoia/agitation.<br><br>R88's progress notes and Medication Administration Records (MAR) were reviewed since admission and revealed the following:<br><br>-Progress note dated 2/27 at 2:54 a.m. R88 slept in a recliner in the TV lounge and refused to go to his bed. Progress note entry at 10:16 a.m. indicated R88 had been yelling his back and bottom hurt, medications were given, and he was transferred to another chair with no relief. Documentation does not reflect evidence of a skin assessment which would have included a skin inspection.<br><br>-Progress note dated 2/28/17, at 4:59 p.m. indicated R88 was demonstrating behaviors. R88 was more restless and his bottom hurt. As needed Seroquel and Trazodone were administered. Documentation does not reflect evidence of a skin assessment which would have included a skin inspection. | 2 900 | | |

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| 2 900 | Continued From page 32<br><br>-MAR dated 3/3/17, indicated on 3/3/17, at 3:04 p.m. as needed dose of Neurontin was administered for buttocks pain and headache. Documentation indicated the dose was not effective. Corresponding progress note indicated staff had repositioned R88 every two hours and applied barrier cream, however, the note lacked evidence that a skin inspection was conducted.<br><br>- MAR dated 3/5/17, indicated at 4:51 p.m. as needed dose of Neurontin was administered for buttocks pain, anxiety, and agitation. Documentation indicated the dose was effective, however, the medical record lacked evidence of a skin inspection to rule out impaired skin integrity.<br><br>-Progress note dated 3/13/17, at 2:45 a.m. indicated R88 had been sleeping in the recliner for the first portion of the night. At 1:22 p.m. as needed dose of Neurontin was administered due to R88 "screaming about butt pain." Documentation indicated dose was effective. However, the medical record lacked evidence that a skin assessment was completed which would have included a skin inspection.<br><br>R88's medical record lacked evidence of routine skin inspections, monitoring, and/or assessment for impaired skin integrity or changes to skin integrity. The medical record revealed no history of open areas to the skin.<br><br>On 3/21/17, at 8:32 a.m. R88 was observed seated in his wheelchair at the dining room table in a slumped position. A pressure reducing seat cushion was noted in the wheelchair. Implementation date of the seat cushion could not be determined. | 2 900 | | |

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| 2 900 | Continued From page 33<br><br>-At 8:36 a.m. R88 planted his feet on the floor and adjusted himself in the chair to a more upright position.<br><br>-At 9:19 a.m. R88 was again in a slumped position while seated in the wheelchair. An unidentified staff member assisted R88 to sit upright by moving behind the wheelchair, wrapping her arms underneath R88's arms and lifted/slid R88 to an upright position.<br><br>-At 2:03 p.m. physical therapist (PT)-D and registered nurse (RN)-C were observed to stand and ambulate R88. R88 took small shuffling steps and required continuous verbal cues from PT-D.<br><br>On 3/22/17, at 7:50 a.m. trained medication assistant (TMA)-B stated it was time to administer R88's medications which included pain pills. R88 was lying in bed when TMA-B entered the room. TMA-B asked R88 if he had any pain in which R88 had denied.<br><br>-At 7:52 a.m. licensed practical nurse (LPN)-D entered the room with R88's medications. R88 stated "leave me alone", LPN-D explained she had medications and he needed to sit up. When TMA-B and LPN-D attempted to assist R88 to sit on the side of the bed, R88 stated "ouch" a couple of times and cried "just leave me alone." LPN-D informed R88 she had his pain pills and he needed to sit up. When R88 was sitting on the edge of the bed, and as LPN-D attempted to administer medications, R88 stated his bottom hurt. R88 continued to be verbally resistive, however cooperative, and LPN-D stated she would administer the rest of the medications after R88 was up and dressed. LPN-D proceeded to | 2 900 | | |

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| 2 900 | Continued From page 34<br>exit the room.<br><br>-At 8:02 a.m. TMA-B donned gloves, directed and assisted R88 to roll over onto his right side. As TMA-B pulled R88's incontinent brief from underneath R88, R88 yelled "ouch, you are hurting me, leave me alone." When TMA-B started to wash R88's bottom, R88 again yelled "ouch." TMA-B stated R88 said ouch quite a bit and continued to wash R88's bottom. Surveyor then requested to inspect R88's skin on his bottom. Inspection revealed a stage two pressure ulcer approximately the size of a pencil eraser on the inside right buttock. The area was slightly raised with an open center. TMA-B indicated she was not aware of the open area and nobody had said anything about R88 having an open area, and R88 did not have any cream in his room to put on it either. TMA-B proceeded to complete R88's morning cares.<br><br>-At 8:21 a.m. LPN-D returned to R88's room, both LPN-D and TMA-B completed R88's cares and assisted him to his wheelchair where LPN-D gave R88 the rest of his pills. LPN-D did not observe the open area and no treatment was provided to the pressure ulcer.<br><br>-At 12:02 p.m. RN-C stated the wound had not been previously reported or identified by facility staff and had not been treated. R88's wound was assessed and determined to be a Stage two (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or presented as an intact or ruptured blister) pressure ulcer which measured 0.6 centimeters (cm) by 0.5 cm with a depth of 0.1 cm, and had scant pink drainage, no tunneling and no maceration. RN-C stated a pressure-relieving mattress was put in place, | 2 900 | | |

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| 2 900 | Continued From page 35<br><br>R88's family was contacted, the doctor would be notified, and a consult would be requested from the dietician. RN-C stated nurses did not look at the skin to evaluate or assess except on admission and with change of condition, however, the NAs looked at each residents' skin daily with cares and would report areas of concern to the nurses. RN-C stated NAs also looked at skin on bath days and would document any noted areas of skin concerns on the bath worksheets, give the worksheet to the nurse and the nurse would transcribe any skin condition concern onto a progress note. When asked if staff kept records of skin monitoring or evidence that a skin inspection was conducted following the identification of a skin concern, RN-C stated no, the worksheets were thrown away once documented onto the progress note. RN-C stated a resident progress note was only written when there was an area of concern identified. RN-C confirmed R88's medical record lacked evidence of routine skin monitoring and evaluations. RN-C stated when a wound was found, nurses were to complete a wound assessment worksheet and the resident would also be added to the facility's weekly wound rounds.<br><br>-At 1:46 p.m. LPN-D stated R88's scheduled bath day was Friday evenings and confirmed the NAs let the nurses know about any resident skin conditions. LPN-D stated the RNs usually completed a comprehensive skin assessment on admission but nurses did not perform whole body skin inspections and did not know how often, if ever, whole body inspections by a nurse was conducted.<br><br>-At 1:58 p.m. NA-I stated residents' skin was checked daily with cares and on bath days and if she saw something, she would report it to the | 2 900 | | |

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| 2 900 | Continued From page 36<br>nurse right away.<br><br>On 3/23/17, at 8:39 a.m. R88 was observed seated in his wheelchair in the lobby area. R88 cried out, "oh God please help me, God please help me I have to go potty, I have to poop!" Surveyor immediately communicated to facility staff R88 had to use the restroom. R88 continued to yell out and became increasingly agitated and fidgety until he was assisted to the bathroom at 8:44 a.m. by NA-H. Once in the bathroom R88 cried out, "Jesus my butt hurts." R88 utilized the grab bar to independently stand up with minimal physical assistance and verbal cues to turn and sit down on the toilet. The Mepilex foam dressing dated 3/22/17, was located over the coccyx area and not covering the pressure ulcer on the right inside buttock. NA-H removed the dressing which revealed another stage two pressure ulcer on the coccyx which was slightly smaller than the wound on the right buttock. It was oval shaped with a pink wound bed. NA-H stated she had last worked on Monday and the wound on the coccyx was not there at that time. However, NA-H stated the other wound had always been there. NA-H stated the area would get red, cream would be applied and the next day the area would be gone and in a couple of days the areas would be back again. NA-H confirmed she reported to the nurse when she found skin problems and bath documentation sheets were used to write down any impaired skin integrity. NA-H applied barrier cream to the coccyx wound without obtaining direction from a nurse.<br><br>-At 8:55 a.m. RN-C entered the room. The barrier cream was removed from the coccyx by NA-H. RN-C confirmed the wound had not been | 2 900 | | |

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| 2 900 | Continued From page 37<br>previously reported or identified by facility staff and had not been treated. RN-E looked at the wound and stated it was not open, however, wanted another nurse that had better eyes to assess the coccyx wound. A flash light was obtained for better viewing related to poor lighting in the bathroom and once viewed under the flashlight, RN-C confirmed the wound was open and assessed the wound to be a stage two pressure ulcer which measured 0.5 cm by 0.2 cm with a depth of less than 0.1 cm. The area was cleansed and large foam dressing was applied to cover and protect both pressure ulcers.<br><br>-at 9:51 a.m. RN-C stated R88 has had multiple wheelchair changes related to reports of discomfort and confirmed she had observed the skin each time the wheelchair was changed, however had not documented any findings. RN-C stated the skin should be inspected when there were reports of bottom discomfort. The director of nursing (DON) stated she had toileted R88 on Tuesday 3/21/17, and had not noted any impaired skin integrity. The DON stated the NAs looked at residents' skin on a daily basis and also on bath days and reported any concerns to the nurse and the nurses would informally look at the skin when something was brought to their attention. The DON verified the nurses looked at residents' skin and completed the Braden Scale assessment on admission and then weekly for three weeks and then with change of condition.<br><br>-At 1:23 p.m. RN-C indicated interventions implemented included a new mattress, repositioning R88 every hour, cleanse area, apply Mepliex dressing to inner and upper right buttock, change every three days and check position of the dressing every shift and staff to inform the | 2 900 | | |

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| 2 900 | Continued From page 38<br>nurse if the dressing was not staying in place. Would also recommend labs to the physician, look into changing seat cushion, lanispetic barrier cream to be applied, request a dietary consult and wounds to be evaluated by the RN weekly and weekly skin checks by the LPN.<br><br>R89 was at risk for pressure ulcers and the staff failed to provide every one hour turning and repositioning and failed to ensure pressure reducing boots were applied at all times, as directed by the care plan.<br><br>R89's quarterly MDS dated 1/15/17, indicated R89 had diagnoses which included stage 3 chronic kidney disease, chronic obstructive pulmonary disease, anemia and diabetes. The MDS also indicated R89 was cognitively intact, was non-ambulatory, required extensive assist of two persons for bed mobility and dressing, extensive assist of one person for personal hygiene and was totally dependent on two persons for transfers and toilet use. The MDS further indicated R89 had one unhealed, stage 2 pressure ulcer present on admission to the facility.<br><br>R89's Pressure Ulcer CAA dated 10/27/16, indicated R89 required total assist with bathing and was always incontinent of bowel and bladder. The CAA indicated R89 was at risk for pressure sores, worsening urinary tract infections/sepsis, gangrene, discomfort and weight loss which was complicated by current cellulitis, severe pain, dependence on staff for bed mobility and toileting needs, diabetes and chronic kidney disease. | 2 900 | | |

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| 2 900 | Continued From page 39<br><br>R89's undated Care Plan indicated R89 had potential for alteration in skin integrity related to pressure sore on left heel and directed staff to implement the following interventions:<br>--turn and reposition every one hour and as needed<br>--provide perirectal care after each incontinent episode.<br>--monitor for persistent red areas and report to registered nurse (RN)<br>--maintain adequate nutrition and hydration by providing dietary decub [decubitus] program<br>--wound care/dressing change as ordered.<br>--keep skin clean and dry.<br>--APP [alternating pressure pad] mattress on bed.<br>--pressure relief boots on both feet as ordered.<br><br>R89's undated Nursing Assistant Care Worksheet directed staff to turn and reposition R89 every one hour and indicated R89 needed to have Prevalon boots (heel offloading device to help prevent the development of heel pressure injuries) on at all times except when bathing.<br><br>R89's Physician Order Report dated 2/23/17-3/23/17, included an order to wear Prevalon (blue) heel lift boots at all times except for bathing. Ensure heel is in proper position.<br><br>R89's Braden Scale dated 2/21/17, indicated R89 was at moderate risk for skin breakdown.<br><br>R89's Tissue Tolerance Assessment dated 10/15/16, directed staff to reposition R89 while in | 2 900 | | |

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| 2 900 | Continued From page 40<br>the wheelchair, chair or recliner every one hour and to turn and reposition every one hour when in bed.<br><br>On 3/22/17, from 7:03 a.m. until 8:28 a.m. (1 hour 25 minutes) R89 was continuously observed sleeping in bed, lying on her back under the covers, with her shoulders positioned slightly to the right. R89 was not repositioned or offered repositioning during this time. Unable to determine if R89's Prevalon boots were on, as directed.<br>R89 was again continuously observed in bed, lying on her back from 9:16 a.m. to 10:47 a.m. without staff assistance to reposition.<br>--at 10:47 a.m. R89 was observed in bed positioned on her back, awake and watching television. R89 stated she liked to sleep in in the morning and no one had come in to get her up for the day yet.<br>--at 10:52 a.m. LPN-A entered R89's room and administered R89's insulin in the abdomen and immediately exited the room. R89 remained positioned on her back. LPN-A did not offer nor provide repositioning assistance.<br>--at 11:26 a.m. (after 2 hours and 10 minutes) NA-C stated she had last been in R89's room at 9:15 a.m. at which time she checked R89's incontinence brief and asked R89 if she wanted to get up for the day in which R89 declined to get up. R89's brief was dry at that time. NA-C entered R89's room, gathered a bathing supplies and proceeded to assist R89 with morning cares. NA-C uncovered R89 and she was noted to be wearing blue Prevalon boots on both feet. NA-C removed the boots which revealed a gauze dressing to R89's left heel. R89's right heel was intact and without redness. Following perirectal cares, R89 assisted with turning by pulling her | 2 900 | | |

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| 2 900 | Continued From page 41 | 2 900 | | |

shoulders over with the use of a grab bar. However, NA-C was required to assist the turn by pulling a sheet under R89's hips and pushing her hips to lift them off the bed. R89's buttocks were intact with a small pea sized light red area noted to her right buttock. NA-C indicated R89 was to be repositioned every two hours but used to be turned every hour when R89 had an open sore to her heel. NA-A entered the room with a mechanical lift and NA-A and NA-C proceeded to transfer R89 to the wheelchair via the lift. R89's wheelchair was equipped with a seat cushion and a padded board was across the calf support area of the wheelchair foot/leg rests. The leg rests were raised. NA-C assisted R89 to complete her morning cares and then wheeled R89 out of her room and to the dining room at approximately 12:00 p.m. R89's Prevalon boots were not reapplied.

On 3/22/2017, at 1:27 p.m. RN-A stated NA-C had come to her after assisting R89 up for the day and indicated she had thought R89's turning and repositioning schedule was for every two hours. RN-A verified R89's current repositioning schedule was for every one hour.

On 3/22/2017, at 1:37 p.m. R89 was observed in her room, seated in the wheelchair. LPN-A stated she had just assisted R89 to put on her Prevalon boots. LPN-A verified R89 did not have them on and confirmed she should have them on at all times due to issues with her heels. NA-C asked LPN-A, "Aren't we supposed to release them once in a while?" LPN-A informed NA-C the boots should be on at all times.

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| 2 900 | Continued From page 42<br>On 3/22/17 at 1:40 p.m. NA-C confirmed she had not put R89's Prevalon boots on when she assisted R89 up for the day and should have done so. NA-C verified the boots were off for approximately one hour and 30 minutes.<br><br>On 3/23/2017, at 9:51 a.m. RN-A verified R89 was admitted to the facility with a left heel ulcer which had recently healed and also had a history of pressure ulcers to her bottom. RN-A confirmed R89 should have been turned and repositioned every one hour and should have had the Prevalon boots on at all times except for bathing, as directed on the care plan.<br><br>R15 was at risk for pressure related sores and did not receive timely turning and repositioning assistance as directed by the care plan.<br><br>R15's quarterly MDS dated 1/16/17, indicated R15 had intact cognition and required extensive assistance of two staff for transfers, required extensive assist of two for bed mobility and had no rejection of cares.<br><br>R15's Activity of Daily Living Functional Status, CAA dated 10/23/16, indicated R15 was diagnosed with diabetic neuropathy, chronic obstructive pulmonary disease and bilateral lower extremity amputations. The CAA indicated R15 required extensive assist with repositioning and was at risk for infection, skin rashes/breakdown, and pressure ulcers.<br><br>R15's care plan dated 1/18/17, indicated R15 had | 2 900 | | |

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| 2 900 | Continued From page 43<br>decreased physical mobility related to bilateral lower extremity amputation with the inability to transfer, turn, reposition self, to sit up or lie down. Staff were directed to provide extensive assist of two to turn and reposition R15 every hour. The NA worksheets, directed staff to turn and reposition R15 every hour.<br><br>R15's Braden Scale dated 3/20//17, indicated R15 was at risk for pressure ulcers due to inability to bear her own weight and make frequent or significant changes in position.<br><br>On 3/22/17, during continuous observations from 7:15 a.m. to 11:00 a.m. R15 was observed to remain seated in her wheelchair without receiving assistance.<br>-At 7:45 a.m. R15 was observed to propel her wheelchair to the dining room for breakfast and returned to her room.<br>-At 9:04 a.m. LPN-A entered R15's room to administer medication and exited the room. LPN-A did not offer nor provide R15 repositioning assistance.<br>-At 9:53 a.m. R15's call light was observed on.<br>-At 9:58 a.m. NA-C entered R15's room, turned the call light off and immediately exited the room.<br>-At 10:00 a.m. R15 stated she had told the NA-C she needed her incontinent brief changed and the NA stated she would be back to help her because she was busy with another resident.<br>-At 10:18 a.m. NA-C returned to R15's room and proceeded to assist R15's roommate.<br>-At 10:35 a.m. NA-C began to assist R15. R15 asked her what she was doing and NA-C informed R15 she was going lay her down. R15 stated she did not want to lie down. NA-C stopped assisting R15 and stated R15 refused a | 2 900 | | |

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| 2 900 | Continued From page 44<br>lot. When asked by the surveyor if she would lay down so staff could change her incontinent brief, R15 stated that was why she had turned the call light on in the first place.<br>-At 10:45 a.m. NA-C proceeded to provide R15 incontinent cares. When removed, the incontinent brief was observed heavily saturated with urine. NA-C confirmed the brief was saturated. NA-C proceeded to cleanse R15's peri area with wipes. R15 asked NA-C what are you doing, NA-C stated she needed to cleanse R15 well due to R15's peri area scratches. Upon completing the peri care, NA-C stated she needed to get the nurse and would be right back. NA-C returned to the room with LPN-A who applied a Tegaderm dressing to R15's right buttock covering an open area. LPN-A informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 CM by 0.50 cm. LPN-A stated R15 frequently scratched her body including her peri area resulting in open areas and scratch marks. LPN-A stated she applied the dressing to help prevent infection. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently fell off.<br>-At 10:58 a.m. R15's cares were completed. NA-C confirmed R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had not provided R15 with turning and repositioning and incontinence cares until just now.<br>-At 10:59 a.m. NA-B entered R15's room. NA-B stated she had assisted R15 up at 7:00 a.m. and pointed to a white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B verified 7:00 a.m. was noted on the board. NA-B confirmed she had not provided turning and repositioning assistance for R15 since 7:00 a.m. (three hours | 2 900 | | |

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| HAVENWOOD CARE CENTER | 1633 DELTON AVENUE BEMIDJI, MN 56601 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 2 900 | Continued From page 45<br>and 30 minutes earlier). NA-B referred to the NA worksheet which she removed from her pocket and verified R15 was to be repositioned every hour. NA-B stated even though R15 could tell us she needed help, it was staff's responsibility to provide the cares without R15 having to ask us.<br><br>On 3/22/17, at 11:10 a.m. the DON confirmed R15 should have been repositioned every hour as directed by the care plan.<br><br>A Resident Care Planning Policy and Procedure, reviewed 4/2015, indicated the care plan was to promote optimal resident independence and quality of care by focusing and directing staff efforts to individual needs and to promote appropriated utilization and coordination of services.<br><br>The Pressure Ulcer Prevention Policy dated 4/2015, indicated the facility pressure ulcer prevention protocol included but was not limited to development of turning and positioning schedules of at least every two hours or more often if condition indicates.<br><br>Facility protocol Skin Care last reviewed 1/2015, indicated on admission a comprehensive skin assessment would be completed and used to develop a comprehensive care plan. The components of the comprehensive assessment included a Braden's scale weekly times four weeks, skin assessment-completed with the initial admission assessment, assessment for pressure relieving devices and a tissue tolerance test assessment. Other scheduled assessments | 2 900 | | |

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| 2 900 | Continued From page 46<br>included the Braden's scale quarterly and with significant change in status, skin assessment with significant change status, weekly body audit on bath days, Tissue Tolerance Test with a significant change in condition. The protocol also indicated staff would apply moisture barrier cream to perirectal area daily, as needed.<br><br>SUGGESTED METHOD OF CORRECTION:<br>The director of nursing (DON) or designee could review/revise policies/procedures for pressure ulcer prevention and care, educate staff and perform audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 2 900 | | |
| 2 905 | MN Rule 4658.0525 Subp. 4 Rehab - Positioning<br><br>Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely repositioning in order to prevent the development of pressure related ulcers as directed by the care | 2 905 | | |

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| 2 905 | Continued From page 47<br>plan for 2 of 4 residents (R89, R15) reviewed for pressure ulcers.<br><br>Finding include:<br><br>R89 was at risk for pressure ulcers and the staff failed to provide every one hour turning and repositioning and failed to ensure pressure reducing boots were applied at all times, as directed by the care plan.<br><br>R89's quarterly MDS dated 1/15/17, indicated R89 had diagnoses which included stage 3 chronic kidney disease, chronic obstructive pulmonary disease, anemia and diabetes. The MDS also indicated R89 was cognitively intact, was non-ambulatory, required extensive assist of two persons for bed mobility and dressing, extensive assist of one person for personal hygiene and was totally dependent on two persons for transfers and toilet use. The MDS further indicated R89 had one unhealed, stage 2 pressure ulcer present on admission to the facility.<br><br>R89's Pressure Ulcer Care Area Assessment (CAA) dated 10/27/16, indicated R89 required total assist with bathing and was always incontinent of bowel and bladder. The CAA indicated R89 was at risk for pressure sores, worsening urinary tract infections/sepsis, gangrene, discomfort and weight loss which was complicated by current cellulitis, severe pain, dependence on staff for bed mobility and toileting needs, diabetes and chronic kidney disease. | 2 905 | | |

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| 2 905 | Continued From page 48<br><br>R89's undated Care Plan indicated R89 had potential for alteration in skin integrity related to pressure sore on left heel and directed staff to implement the following interventions:<br>--turn and reposition every one hour and as needed<br>--provide perirectal care after each incontinent episode.<br>--monitor for persistent red areas and report to registered nurse (RN)<br>--maintain adequate nutrition and hydration by providing dietary decub [decubitus] program<br>--wound care/dressing change as ordered.<br>--keep skin clean and dry.<br>--APP [alternating pressure pad] mattress on bed.<br>--pressure relief boots on both feet as ordered.<br><br>R89's undated Nursing Assistant Care Worksheet directed staff to turn and reposition R89 every one hour and indicated R89 needed to have Prevalon boots (heel offloading device to help prevent the development of heel pressure injuries) on at all times except when bathing.<br><br>R89's Physician Order Report dated 2/23/17-3/23/17, included an order to wear Prevalon (blue) heel lift boots at all times except for bathing. Ensure heel is in proper position.<br><br>R89's Braden Scale dated 2/21/17, indicated R89 was at moderate risk for skin breakdown.<br><br>R89's Tissue Tolerance Assessment dated 10/15/16, directed staff to reposition R89 while in the wheelchair, chair or recliner every one hour | 2 905 | | |

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| 2 905 | Continued From page 49<br>and to turn and reposition every one hour when in bed.<br><br>On 3/22/17, from 7:03 a.m. until 8:28 a.m. (1 hour 25 minutes) R89 was continuously observed sleeping in bed, lying on her back under the covers, with her shoulders positioned slightly to the right. R89 was not repositioned or offered repositioning during this time. Unable to determine if R89's Prevalon boots were on, as directed.<br>R89 was again continuously observed in bed, lying on her back from 9:16 a.m. to 10:47 a.m. without staff assistance to reposition.<br>--at 10:47 a.m. R89 was observed in bed positioned on her back, awake and watching television. R89 stated she liked to sleep in in the morning and no one had come in to get her up for the day yet.<br>--at 10:52 a.m. LPN-A entered R89's room and administered R89's insulin in the abdomen and immediately exited the room. R89 remained positioned on her back. LPN-A did not offer nor provide repositioning assistance.<br>--at 11:26 a.m. (after 2 hours and 10 minutes) NA-C stated she had last been in R89's room at 9:15 a.m. at which time she checked R89's incontinence brief and asked R89 if she wanted to get up for the day in which R89 declined to get up. R89's brief was dry at that time. NA-C entered R89's room, gathered a bathing supplies and proceeded to assist R89 with morning cares. NA-C uncovered R89 and she was noted to be wearing blue Prevalon boots on both feet. NA-C removed the boots which revealed a gauze dressing to R89's left heel. R89's right heel was intact and without redness. Following perirectal cares, R89 assisted with turning by pulling her shoulders over with the use of a grab bar. | 2 905 | | |

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| 2 905 | Continued From page 50 | 2 905 | | |

However, NA-C was required to assist the turn by pulling a sheet under R89's hips and pushing her hips to lift them off the bed. R89's buttocks were intact with a small pea sized light red area noted to her right buttock. NA-C indicated R89 was to be repositioned every two hours but used to be turned every hour when R89 had an open sore to her heel. NA-A entered the room with a mechanical lift and NA-A and NA-C proceeded to transfer R89 to the wheelchair via the lift. R89's wheelchair was equipped with a seat cushion and a padded board was across the calf support area of the wheelchair foot/leg rests. The leg rests were raised. NA-C assisted R89 to complete her morning cares and then wheeled R89 out of her room and to the dining room at approximately 12:00 p.m. R89's Prevalon boots were not reapplied.

On 3/22/2017, at 1:27 p.m. RN-A stated NA-C had come to her after assisting R89 up for the day and indicated she had thought R89's turning and repositioning schedule was for every two hours. RN-A verified R89's current repositioning schedule was for every one hour.

On 3/22/2017, at 1:37 p.m. R89 was observed in her room, seated in the wheelchair. LPN-A stated she had just assisted R89 to put on her Prevalon boots. LPN-A verified R89 did not have them on and confirmed she should have them on at all times due to issues with her heels. NA-C asked LPN-A, "Aren't we supposed to release them once in a while?" LPN-A informed NA-C the boots should be on at all times.

On 3/22/17 at 1:40 p.m. NA-C confirmed she had

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| 2 905 | Continued From page 51<br>not put R89's Prevalon boots on when she assisted R89 up for the day and should have done so. NA-C verified the boots were off for approximately one hour and 30 minutes.<br><br>On 3/23/2017, at 9:51 a.m. RN-A verified R89 was admitted to the facility with a left heel ulcer which had recently healed and also had a history of pressure ulcers to her bottom. RN-A confirmed R89 should have been turned and repositioned every one hour and should have had the Prevalon boots on at all times except for bathing, as directed on the care plan.<br><br>R15 was at risk for pressure related sores and did not receive timely turning and repositioning assistance as directed by the care plan.<br><br>R15's quarterly MDS dated 1/16/17, indicated R15 had intact cognition and required extensive assistance of two staff for transfers, required extensive assist of two for bed mobility and had no rejection of cares.<br><br>R15's Activity of Daily Living Functional Status, CAA dated 10/23/16, indicated R15 was diagnosed with diabetic neuropathy, chronic obstructive pulmonary disease and bilateral lower extremity amputations. The CAA indicated R15 required extensive assist with repositioning and was at risk for infection, skin rashes/breakdown, and pressure ulcers.<br><br>R15's care plan dated 1/18/17, indicated R15 had decreased physical mobility related to bilateral | 2 905 | | |

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| 2 905 | Continued From page 52<br>lower extremity amputation with the inability to transfer, turn, reposition self, to sit up or lie down. Staff were directed to provide extensive assist of two to turn and reposition R15 every hour. The NA worksheets, directed staff to turn and reposition R15 every hour.<br><br>R15's Braden Scale dated 3/20//17, indicated R15 was at risk for pressure ulcers due to inability to bear her own weight and make frequent or significant changes in position.<br><br>On 3/22/17, during continuous observations from 7:15 a.m. to 11:00 a.m. R15 was observed to remain seated in her wheelchair without receiving assistance.<br>-At 7:45 a.m. R15 was observed to propel her wheelchair to the dining room for breakfast and returned to her room.<br>-At 9:04 a.m. LPN-A entered R15's room to administer medication and exited the room. LPN-A did not offer nor provide R15 repositioning assistance.<br>-At 9:53 a.m. R15's call light was observed on.<br>-At 9:58 a.m. NA-C entered R15's room, turned the call light off and immediately exited the room.<br>-At 10:00 a.m. R15 stated she had told the NA-C she needed her incontinent brief changed and the NA stated she would be back to help her because she was busy with another resident.<br>-At 10:18 a.m. NA-C returned to R15's room and proceeded to assist R15's roommate.<br>-At 10:35 a.m. NA-C began to assist R15. R15 asked her what she was doing and NA-C informed R15 she was going lay her down. R15 stated she did not want to lie down. NA-C stopped assisting R15 and stated R15 refused a lot. When asked by the surveyor if she would lay | 2 905 | | |

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| 2 905 | Continued From page 53 | 2 905 | | |

down so staff could change her incontinent brief, R15 stated that was why she had turned the call light on in the first place.
-At 10:45 a.m. NA-C proceeded to provide R15 incontinent cares. When removed, the incontinent brief was observed heavily saturated with urine. NA-C confirmed the brief was saturated. NA-C proceeded to cleanse R15's peri area with wipes. R15 asked NA-C what are you doing, NA-C stated she needed to cleanse R15 well due to R15's peri area scratches. Upon completing the peri care, NA-C stated she needed to get the nurse and would be right back. NA-C returned to the room with LPN-A who applied a Tegaderm dressing to R15's right buttock covering an open area. LPN-A informed R15 she had a small open area on her bottom from scratching. LPN-A stated the open area measured approximately 0.25 CM by 0.50 cm. LPN-A stated R15 frequently scratched her body including her peri area resulting in open areas and scratch marks. LPN-A stated she applied the dressing to help prevent infection. LPN-A further stated, due to R15's incontinence and wet skin, the dressing frequently fell off.
-At 10:58 a.m. R15's cares were completed. NA-C confirmed R15's brief was heavily saturated with urine and her skin was wet. NA-C stated she had not provided R15 with turning and repositioning and incontinence cares until just now.
-At 10:59 a.m. NA-B entered R15's room. NA-B stated she had assisted R15 up at 7:00 a.m. and pointed to a white marker board in R15's room and stated staff documented the last time cares were provided on the board. NA-B verified 7:00 a.m. was noted on the board. NA-B confirmed she had not provided turning and repositioning assistance for R15 since 7:00 a.m. (three hours and 30 minutes earlier). NA-B referred to the NA

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| 2 905 | Continued From page 54<br>worksheet which she removed from her pocket and verified R15 was to be repositioned every hour. NA-B stated even though R15 could tell us she needed help, it was staff's responsibility to provide the cares without R15 having to ask us.<br><br>On 3/22/17, at 11:10 a.m. the DON confirmed R15 should have been repositioned every hour as directed by the care plan.<br><br>A Resident Care Planning Policy and Procedure, reviewed 4/2015, indicated the care plan was to promote optimal resident independence and quality of care by focusing and directing staff efforts to individual needs and to promote appropriated utilization and coordination of services.<br><br>The Pressure Ulcer Prevention Policy dated 4/2015, indicated the facility pressure ulcer prevention protocol included but was not limited to development of turning and positioning schedules of at least every two hours or more often if condition indicates.<br><br>Facility protocol Skin Care last reviewed 1/2015, indicated on admission a comprehensive skin assessment would be completed and used to develop a comprehensive care plan. The components of the comprehensive assessment included a Braden's scale weekly times four weeks, skin assessment-completed with the initial admission assessment, assessment for pressure relieving devices and a tissue tolerance test assessment. Other scheduled assessments included the Braden's scale quarterly and with | 2 905 | | |

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| 2 905 | Continued From page 55<br>significant change in status, skin assessment with significant change status, weekly body audit on bath days, Tissue Tolerance Test with a significant change in condition. The protocol also indicated staff would apply moisture barrier cream to perirectal area daily, as needed.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies/procedures for pressure ulcer prevention and care, educate staff and perform audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 2 905 | | |
| 21390 | MN Rule 4658.0800 Subp. 4 A-I Infection Control<br><br>Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:<br>A. surveillance based on systematic data collection to identify nosocomial infections in residents;<br>B. a system for detection, investigation, and control of outbreaks of infectious diseases;<br>C. isolation and precautions systems to reduce risk of transmission of infectious agents;<br>D. in-service education in infection prevention and control;<br>E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections;<br>F. the development and implementation of | 21390 | | |

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| 21390 | Continued From page 56<br>employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815;<br>G. a system for reviewing antibiotic use;<br>H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and<br>I. methods for maintaining awareness of current standards of practice in infection control.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use was provided for 1 of 1 resident (R15) observed during the provision of personal cares.<br><br>Findings include:<br><br>On 3/21/17, at 2:15 p.m. nursing assistant (NA)-E and NA-D were observed to transfer R15 to her bed to provide incontinence cares. NA-E obtained a clean brief, perineal cleansing wipes and a tube of lanoseptic barrier cream. Both NA's washed hands and applied gloves. NA-E removed tape from R15's brief and lowered the brief. The brief was observed saturated with yellow urine. NA-E used both gloved hands to turn and removing the wet brief from under R15. R15's perineal skin was wet with urine and also had red scratch marks and a tegaderm dressing on the right buttock.<br><br>-2:17 p.m. NA-E obtained a cleansing wipe, and | 21390 | | |

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| 21390 | Continued From page 57 | 21390 | | |

wiped R15's buttocks area, turning the wipe over several times to wipe the area. NA-E picked up the barrier cream with her right gloved hand and applied the barrier cream to her soiled left gloved hand and applied the cream to R15's buttock area. NA-E removed her soiled left glove and tossed it in the trash. NA-E and NA-D positioned R15 onto her back. R15 was noted to have scratched her periarea at this time. NA-E obtained cleansing wipes and proceeded to wipe R15's periarea. NA-E picked up the lanoseptic barrier cream with her left hand and applied the barrier cream to R15's front periarea. NA-E removed right soiled glove and with assistance from NA-D, applied R15's clean brief, adjusted her clothing and transferred R15 back into her wheelchair. NA-E was not observed to change her gloves during the pericare and application of creams using soiled gloves. NA-D was not observed to provide assistance with cleansing or application of barrier cream. R15 was not observed to be offered or provided hand washing following scratching her periarea.

On 3/21/17, at 2:38 p.m. NA-E verified R15 was incontinent of urine, frequently scratched her skin including the periarea. NA-E stated R15 scratched her skin frequently resulting in open areas. NA-E confirmed the red areas on R15's peri area was from scratching and the tegaderm on the right buttock covered an open area from scratching.

On 03/21/2017, at 2:42 p.m. registered nurse (RN)-A verfied soiled gloves should have been removed and hands washed and clean gloves

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| 21390 | Continued From page 58<br>reapplied prior to applying barrier cream.<br><br>The facility undated, Application of Ointment, direct staff to wash hands, open the jar or tube, apply gloves, apply ointment, remove gloves and wash hands.<br><br>The facility Perineal Care Procedure policy, review date 4/2015, lacked direction for applying a perineal/barrier cream during perineal cares.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, monitor, evaluate to assure proper hand hygiene was performed during the provision of cares.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21390 | | |
| 21426 | MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control<br><br>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, | 21426 | | |

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| 21426 | Continued From page 59<br>residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.<br><br>(b) Written compliance with this subdivision must be maintained by the nursing home.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure consistent documentation of the two step tuberculin skin test (TST) which would include the induration and interpretation of the test was completed for 5 of 5 residents (R69, R110, R89, R46, R4) and 4 of 5 employees reviewed who lacked the required documentation.<br><br>Findings include:<br><br>R69 was admitted to the facility on 1/20/17. The Resident Tuberculin Skin Test Documentation form indicated R69 was administered the first step TST on 1/21/17, and read on 1/23/17, with documentation of a 0 mm induration. The second step TST was administered on 2/5/17, and read on 2/7/17, with documentation of a 0 mm induration. The readings lacked an interpretation of the results.<br><br>R110 was admitted to the facility on 1/18/17. The Resident Tuberculin Skin Test Documentation indicated R110 was administered the first step | 21426 | | |

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| 21426 | Continued From page 60<br>TST on 1/19/17, and read on 1/21/17, with documentation of a 0 mm induration. The second step TST was administered on 1/29/17, and read on 1/31/17, with documentation of a 0 mm induration. The readings lacked an interpretation of the results.<br><br>R89 was admitted to the facility on 10/14/16. The Resident Tuberculin Skin Test Documentation indicated R89 was administered the first step TST on 10/14/16, and read on 10/16/16, with documentation of a 0 mm induration. The second step TST was administered on 10/24/16, and read on 10/26/16, with documentation of a 0 mm induration. The readings lacked an interpretation of the results.<br><br>R46 was admitted to the facility on 12/27/16. The Resident Tuberculin Skin Test Documentation indicated R46 was administered the first step TST on 12/27/16, and read on 12/30/16, with documentation of a 0 mm induration. The second step TST was administered on 1/22/17, and read on 1/24/17, with documentation of a 0 mm induration. The readings lacked an interpretation of the results.<br><br>R4 was admitted to the facility on 2/15/17. The Resident Tuberculin Skin Test Documentation indicated R4 was administered the first step TST on 2/15/17, and read on 2/18/17, with documentation of a 0 mm induration. The second step TST was administered on 2/25/17, and read on 2/27/17, with documentation of a 0 mm induration. The readings lacked an interpretation of the results | 21426 | | |

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| 21426 | Continued From page 61<br><br>Employee TST<br><br>Employee (EE)-1's start date was 3/2/17. The New Employee Tuberculin Skin Test Documentation Form indicated EE-1 was administered the first TST on 2/27/17, and read on 3/1/17, with documentation of 0 mm induration. The readings lacked an interpretation of the results.<br><br>EE-2's start date was 1/27/17. The New Employee Tuberculin Skin Test Documentation Form indicated EE-2 was administered the first TST on 1/12/17, and read on 1/14/17, with documentation of 0 mm induration. The second step TST was administered on 1/21/17, and read on 1/23/17, with documentation of 0 mm induration. The readings lacked an interpretation of the results.<br><br>EE-3's start date was 2/10/17. The New Employee Tuberculin Skin Test Documentation Form indicated EE-3 was administered the first TST on 2/6/17, and read on 2/8/17, with documentation of 0 mm induration. The second step TST was administered on 3/21/17, and not due to be read at the time of survey. The reading of the first step lacked an interpretation of the results.<br><br>EE-4's start date was 2/27/17. The New Employee Tuberculin skin Test Documentation Form indicated EE-4 was administered the first TST on 2/21/17, and read on 2/23/17, with documentation of 0 mm induration. The second | 21426 | | |

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| 21426 | Continued From page 62<br>step TST was administered on 3/21/17, and not due to be read at the time of survey. The reading of the first step lacked an interpretation of the results.<br><br>On 3/23/17, at 4:00 p.m. the director of nursing confirmed the facility only documented the TST induration and did not document an interpretation of the TST as required.<br><br>Facility policy was requested and not received.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies/procedures for interpreting the Tuberculin Skin Tests and documenting the results, educate staff and perform audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days. | 21426 | | |
| 21540 | MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring<br><br>Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide | 21540 | | |

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| 21540 | Continued From page 63<br>adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to follow physician's orders for the administration of as needed (PRN) sleep medication, failed to identify and differentiate target behaviors for administration of PRN mood stabilizer and antipsychotic medications, and failed to ensure documentation of non-pharmacological interventions attempted or offered prior to the administration of PRN medications. In addition, the facility failed to ensure a nurse, (or other qualified professional) assessed the need for PRN administration and a nurse (or other qualified professional)evaluated the effectiveness of all administered PRN medications. Furthermore, the facility failed to develop a plan of care for impaired sleep integrity and revise the plan of care for pain to include individualized non-pharmacological interventions for 1 of 5 residents (R88) reviewed for unnecessary medications. | 21540 | | |

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| 21540 | Continued From page 64<br>Findings include:<br><br>R88's undated Face Sheet included diagnoses of dementia without behavioral disturbance, fracture of left clavicle and seventh vertebra, overactive bladder, myelodysplastic syndrome, diverticulitis, and anxiety disorder.<br><br>R88's 14 day Medicare Minimum Data Set (MDS) dated 12/25/16, indicated R88 had severe cognitive impairment, mild depression, had trouble falling asleep, staying asleep, or sleeping too much. The admission MDS dated 12/18/16, indicated an increase in depressive symptoms from minimal depression with a score of 4 and also indicated R88 did not have trouble with sleep. The MDS indicated R88 displayed behaviors daily not directed towards others and was taking an antidepressant medication.<br><br>R88's care plan dated 12/28/16, indicated R88 had an alteration in thought process with potential for anxiety related to dementia/impaired cognition and nursing home placement. R88 displayed behaviors such as yelling out, swearing, attempting self-transfers, disrobing, resistive to treatment/cares, hitting out at staff, removing neck brace and arm sling. Interventions directed staff to assist R88 to activities, medicate as ordered, assess pain, offer snack, offer to use toilet, provide movie and music (country western Willie Nelson and Patsy Kline), allow time to express concerns and offer to talk with his daughter, reorient and validate as needed, anticipate needs, provide cues and supervision when making poor decisions. | 21540 | | |

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| 21540 | Continued From page 65<br><br>R88's current physician orders included:<br><br>-Neurontin 100 mg (milligrams) three times a day for low back pain at 8:00 a.m., 2:00 p.m., 8:00 p.m.<br>-Neurontin solution 250mg/5ml (milliliters) give 50 mg every 2 hours PRN for pain, anxiety, restlessness. Max of 6 as needed doses in 24 hours.<br>- Oxycodone 2.5 mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. for low back pain<br>-Tylenol 1000mg three times a day at 8:00 a.m., 2:00 p.m., and 8:00 p.m. for low back pain<br>-Trazodone 50 mg at 8:00 p.m. every night for trouble sleeping, may give one additional tablet PRN after scheduled dose prior to 3:00 a.m.<br>-Effexor extended release 3 capsules every evening at 5 p.m. for anxiety disorder<br>-Seroquel 12.5 mg three times a day at 12:00 p.m., 5:00 p.m., 8:00 p.m. and 12.5 mg PRN for paranoia/agitation not to exceed two as needed doses in 24 hours. Use only when non-pharmacological measures such as offer of snack or drink, toileting, repositioning, massage, distraction with conversation or activity have failed (This order was revised on 3/17/17, to include use of non-pharmacological interventions).<br><br>Trazadone for sleep:<br><br>R88's Medication Administration Record (MAR) from 2/20-3/21/17, revealed the following PRN doses of Trazodone were administered (documentation reflected all scheduled doses given per order): | 21540 | | |

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| 21540 | Continued From page 66<br><br>-2/21 PRN dose administered at 2:53 a.m. for restlessness, result was semi effective. The record lacked documentation of non-pharmacological interventions attempted or offered prior to administration.<br>-2/23 dose administered at 7:04 p.m. for restlessness and was effective however, dose was not given according to physician orders and the record lacked documentation of non-pharmacological interventions attempted or offered prior to administration.<br>-2/28 PRN dose administered at 4:43 p.m. for yelling and unable to redirect however, dose was not given according to physician orders and lacked evidence of non-pharmacological interventions attempted or offered prior to administration. The TMA (trained medication assistant) documented the medication was effective.<br>-3/5 PRN dose administered at 4:36 p.m. for yelling and hollering out, not able to redirect, dose was semi effective however, dose was not given according to physician orders and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration.<br>-3/7 PRN dose administered at 9:19 p.m. given for yelling out and hollering, not able to redirect, documented as effective. The medical record lacked documentation that a nurse assessment was conducted prior to and after the administration of the medication and the medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/10 PRN dose administered at 1:59 a.m. and was noted as effective, however, the MAR lacked documentation of the reason for administration | 21540 | | |

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| 21540 | Continued From page 67<br>and also lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/11 PRN dose administered at 1:50 a.m. for yelling and hollering out and was noted as semi effective however, the MAR and medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/13 PRN dose administered at 1:35 a.m. for hollering and was noted as semi effective however, the medical record and MAR lacked documentation of non-pharmacological interventions offered or attempted prior to the administration of the medication.<br>-3/15 PRN dose administered at 7:00 p.m. for yelling and was noted as not effective. The dose was not given according to physicians orders and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/16 and 3/21 doses administered for yelling and hollering out. The MAR and medication record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br><br>The facility failed to follow physician orders for administration of the Trazadone and lacked documentation of non-pharmacological interventions offered or provided prior to administration and failed to ensure a nurse assessment was conducted prior to and after administration of doses administered by trained medication assistant (TMA). In addition, the facility failed to develop a care plan for impaired sleep which would include non-pharmacological interventions. | 21540 | | |

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| 21540 | Continued From page 68<br><br>Neurontin for pain, anxiety, and restlessness<br><br>R88's medical record did not reflect a differentiation between target behaviors for the administration of Neurontin for pain and for the administration of Seroquel (antipsychotic) or identify which target behaviors were associated with symptoms of anxiety and restlessness versus symptoms of paranoia and agitation in order to determine appropriate medication to administer. Target behaviors identified and monitored included: crying out, attempting to stand without help, and potential for combative with cares.<br><br>R88's Medication Administration Record (MAR) from 2/20-3/21/17, revealed the following as needed doses of Neurontin were administered:<br><br>-2/27 PRN dose administered at 4:20 p.m. for behavioral issue and pain, was semi effective. Medical record lacked behavior and pain documentation and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/3 PRN dose administered by TMA at 3:04 p.m. for bottom hurting and headache, was not effective. Medical record lacked documentation of a nurse assessment prior to the administration in order to assess need and also lacked nurse evaluation of the effectiveness of the medication. TMA indicated non-pharmacological interventions attempted prior to the administration for the bottom pain was repositioning every two hours and applying barrier cream, however no | 21540 | | |

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| 21540 | Continued From page 69<br>measures were indicated for the headache.<br>-3/5 PRN dose administered at 4:51 p.m. for bottom pain, anxiousness and agitation, and was semi-effective. The medical record lacked behavior and pain documentation and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/8 PRN dose was administered at 1:32 p.m. for yelling out and was effective. The medical record lacked documentation of behavior and of non-pharmacological interventions attempted or offered prior to administration.<br>-3/9 PRN dose administered at 9:47 a.m. for pain rated a six out of 10 pain scale and was not effective because resident spit out the medication. The medical record lacked pain documentation and lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/13 PRN dose administered at 1:22 p.m. for screaming about and butt pain. The med was effective. The medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/15 PRN dose administered at 10:26 p.m. for hollering and hitting and was effective. The medical record lacked documentation of non-pharmacological intervention offered or attempted prior to the administration.<br><br>The facility failed to identify specific target behaviors associated with symptoms with anxiety and restlessness in order to justify the administration of as needed doses of Neurontin, and failed to ensure complete documentation of behaviors. In addition, the facility failed to ensure | 21540 | | |

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| 21540 | Continued From page 70<br>a nurse assessed R88 prior to and after administration of all PRN doses administered by the TMA, and failed to document non-pharmacological interventions prior to administration of the PRN doses. In addition, the facility failed to revise a care plan for pain to include non-pharmacological interventions.<br><br>Seroquel for paranoia/agitation:<br><br>R88's pharmacy record indicated on 3/1/17, the consultant pharmacist informed the facility the PRN dose of Seroquel required identification of target behaviors and non-drug (non-pharmacological) interventions to be attempted prior to administration of the medication. The report also indicated the physician need not be contacted, but nursing staff should address as soon as possible (a copy of the pharmacists' recommendation was requested and not received). The physician's orders reflected the direction to use non-pharm interventions prior to administration of medication was not added until 3/17/17.<br><br>R88's record did not reflect a differentiation between target behaviors for the administration of Seroquel and for the administration of Neurontin or identify which target behaviors were associated with symptoms of anxiety and restlessness versus symptoms of paranoia and agitation in order to determine appropriate medication. Target behaviors identified and monitored included: crying out, attempting to stand without help, and potential for combative with cares. | 21540 | | |

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| 21540 | Continued From page 71<br>R88's nursing progress notes, daily documentation of behavior monitoring, and the MAR were reviewed from 2/20-3/21/17, and revealed the following documentation on administration of the as needed Seroquel:<br><br>-2/21 at 2:53 a.m. dose administered for behavioral issues and was semi effective. The medical record lacked documentation of behavior displayed and non-pharmacological interventions attempted prior to the administration.<br>-2/21 progress note entered at 1:06 p.m. indicated R88 received as needed Seroquel for behaviors this shift. Medication appears to be effective. However, the record lacked documentation of the time administered, behavior displayed and non-pharmacological interventions attempted or offered prior to administration.<br>-2/26 at 9:58 p.m. dose administered for behavioral issues and was not effective. The medical record lacked documentation of behavior displayed and non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-2/27 at 4:20 p.m. for behavioral issues and was semi effective. The medical record lacked documentation of behavior displayed and non-pharmacological interventions attempted or offered prior to the administration of the medication.<br>-3/1 progress note entered at 5:53 p.m. indicated a dose was given at that time for yelling out and causing disruptions. No further information was evident in the record. Documentation lacked evidence non pharmacological interventions were offered or attempted prior to the administration of the medications and an evaluation of effectiveness of administered dose.<br>-3/5 progress note entered at 9:08 p.m. indicated | 21540 | | |

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| 21540 | Continued From page 72<br>a dose was administered around 4:00 p.m. by a TMA for hollering out and did not respond to redirection. Documentation lacked time of administration and lacked a nurse assessment of the behavior prior to and after administration of medication. In addition, the record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication and lacked an evaluation of medication effectiveness.<br>-3/7 progress note entered at 9:28 p.m. indicated a dose was administered by a TMA for hollering out help me and was not able to redirect. Documentation lacked time of administration and lacked a nurse's assessment of behavior prior to and after administration of medication. In addition, the medical record lacked documentation of non-pharmacological interventions attempted or offered prior to the administration of the medication and lacked evaluation of medication effectiveness.<br>-3/11 progress note entered at 6:47 p.m. and progress noted 3/12 at 4:40 a.m. indicated a dose was administered for yelling and hollering. The medical record lacked time of dose, non-pharmacological interventions attempted or offered prior to the administration of the medication and an evaluation of effectiveness.<br>-3/13 progress not entered at 5:47 p.m., 3/14 progress note entered at 5:39 p.m., and 3/15 progress note entered at 6:30 p.m. all indicated a dose was given for behaviors. The medical lacked documentation of target behaviors, times of medication administration, evaluations for effectiveness and non-pharmacological interventions attempted or offered prior to the administration of the medication.<br><br>The facility failed to identify specific (target) | 21540 | | |

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| 21540 | Continued From page 73<br>behaviors associated with symptoms of paranoia and agitation after the consultant pharmacist recommended the need for identification of target behaviors and failed to immediately identify non-pharmacological interventions in order to justify the administration of as needed doses. In addition, the facility failed to ensure complete documentation of behaviors, failed to ensure a nurse assessed R88's behaviors prior to and after administration of as needed doses administered by TMA, and failed to document non-pharmacological interventions attempted prior to the administration of as needed doses.<br><br>On 3/21/17, at 8:32 a.m. R88 was observed seated at the dining room table sobbing (but was not tearful) intermittently. NA-L sat next to him. NA-L explained R88 was not doing well because he thought his wife was dead which she was not. NA-L asked R88 if he wanted to talk about it, R88 responded by stating he wanted to go out to the woods to pray. R88 was asked what his favorite prayer was and stopped sobbing and stated he was Christian and his favorite prayer was Come Lord Jesus.<br>-at 9:16 a.m. R88 was seated in the TV viewing area in his wheelchair crying repeatedly help me doctor, help me doctor! An unidentified staff member walked by and stated the doctor was not in today and walked away. R88 resumed calling out for his doctor.<br>-At 9:19 a.m. unidentified staff member repositioned R88 in his wheelchair and informed the resident he was going to therapy and assisted him to therapy<br>R88's medical record on 3/21 did not reflect evidence of the expressed behaviors the facility had identified as target behaviors. | 21540 | | |

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| 21540 | Continued From page 74<br><br>On 3/22/17, at 7:52 a.m. licensed practical nurse (LPN)-D entered the room with R88's medications. R88 stated leave me alone, LPN-D explained she had medications and he needed to sit up. When TMA-B and LPN-D attempted to assist R88 to sit on the side of the bed, R88 exclaimed ouch a couple of times and cried just leave me alone. LPN-D explained to R88 she had his pain pills and he needed to sit up. When R88 was seated on the edge of the bed as LPN-D attempted to administer medications, R88 stated my bottom hurts. R88 continued to be verbally resistive, however cooperative. LPN-D indicated she would administer the rest of the medication after he was up and dressed and directed TMA-B to complete cares. LPN-D exited the room. As TMA-B washed and dressed R88, R88 stated leave me alone just leave me alone, get out of here. After each time R88 made the statements, TMA-B gave encouragement quietly and calmly, explained what she was doing, used distraction with other topics, and tried to engage R88 in conversation. Although R88 was verbally resistive, he was cooperative.<br><br>R88's Behavior/Mood flow sheet for 3/22, written following the above observations indicated merely read "behaviors during cares" and did not specify what the behavior was. The flow sheet indicated the behaviors occurred at 7 a.m. and all interventions were attempted. The documentation indicated the response to the interventions was resistive at first, but after 2-3 attempts behavior/mood stopped.<br><br>On 3/23/17, at 8:39 a.m. R88 was observed seated in his wheelchair in the lobby area. R88 | 21540 | | |

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| 21540 | Continued From page 75 | 21540 | | |

cried out repeatedly, "oh God please help me, God please help me I have to go potty, I have to poop!" Surveyor immediately communicated to facility staff R88 had to use the restroom. R88 continued to yell out and became increasingly agitated and fidgety until he was assisted to the bathroom at 8:44 a.m. by NA-H.

R88's medical record on 3/23/17 did not reflect documentation of the observed behaviors the facility had identified as target behaviors.

On 3/21/17, at 2:13 p.m. NA-I stated R88 was very expressive, yelled out "help me, help me" all the time, doesn't know what he needed or wants, and yelled out every day all day. NA-I reported R88 was much better since return from the behavior unit. Staff utilized redirection when he displayed behaviors and most of the time was easily redirectable.

-At 2:15 p.m. NA-J reported R88 yelled out all day every day and staff would attempt as many interventions as we could. NA-J stated R88's behaviors were better since he returned from the behavioral unit.

-At 3:28 p.m. NA-K stated R88 got anxious and yelled out, indicated R88 displayed more behaviors when he was not busy doing something.

On 3/23/17, at 8:38 a.m. TMA-B indicated when a resident asked for an as needed medication, she needed to figure out what it was for and check to see when the last as needed medication was administered. TMA-B stated after the medication was given she would go back to see if it was

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| 21540 | Continued From page 76<br>effective. TMA-B stated she could not administer narcotic medication as a nurse was required to give it. When asked when she would administer R88's Seroquel, TMA-B stated if he was agitated, yelling, screaming, and hitting staff. TMA-B indicated she would administer Trazodone for hard time sleeping or if agitated and trying to get out of bed. TMA-B stated she would administer Neurontin based on facial expression, if he was having pain, and if he was agitated. In response to the question, "How do you know when to administer Seroquel and when to administer Neurontin?" TMA-B stated it depended on how anxious he R88 was and if he was really anxious she would administer the Seroquel. TMA-B stated it was hard to tell exactly what's going on with R88 but if she had any questions on what to administer, she would ask a nurse.<br><br>-At 9:24 a.m. the director of nursing (DON) indicated she was not aware the TMA's were administering as needed medications without a nurse assessment and stated the TMA's were not allowed to determine if as needed medications should be given. The DON confirmed as needed medications required a nurse assessment in order to determine if the medication was appropriate for use, and if the medication was administered, the nurse was to go back and assess the effectiveness of the medication. The DON immediately provided education to the TMA's pertaining to the administration of as needed medications. The DON stated she would administer Neurontin if R88's behaviors of agitation and anxiety manifested by pain and she would administer Seroquel for when R88 displayed agitation and anxiety manifested by delusions or hallucinations. The DON indicated the target behaviors in which to administer the | 21540 | | |

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| 21540 | Continued From page 77<br>medications were not clear. The DON stated behavior documentation should include what the specific behavior was, non-pharmacological interventions attempted and what the response to those intervention were, and effectiveness of the medication, if it had to be administered. The DON verified Trazodone was not administered appropriately and stated R88's physician's orders should have been followed and documentation should have been completed related to non-pharmacological interventions attempted and response to those interventions as well as the effectiveness of the medication, if administered. The DON indicated there have been non-pharmacological interventions in the care plan for sleep and for pain. The documentation of pain should include location of pain, intensity, non-pharmacological interventions and response to them and effectiveness of the as needed pain medication if administered.<br><br>Facility Psychotropic Medication Monitoring policy reviewed April 2015, indicated was to assure psychopharmacological drug therapy was effective and necessary to treat a specific condition that quality of life was enhanced for those residents on these medication. The policy directed staff to fill out a monthly behavior monitoring sheet each time the identified behavior occurred so the doctor could review the frequency of the behaviors and what approaches were beneficial. The policy indicated orders for as needed medication would be given for specific, clearly documented circumstances and specific behaviors and interventions would be listed for as needed psychotropic medications. The policy directed nursing to monitor the residents for presence of target behaviors on a daily basis charting by exception (when behaviors are | 21540 | | |

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| 21540 | Continued From page 78<br>present) and nursing would care plan the resident's specific target behaviors and effective non-pharmacological interventions as well as attach them to the medication on the MAR.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, monitor, evaluate to assure physician orders were followed and medications were adminsitered and monitored appropriately.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21540 | | |
| 21620 | MN Rule 4658.1345 Labeling of Drugs<br><br>Drugs used in the nursing home must be labeled in accordance with part 6800.6300.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to assure the appropriate prescription labels with directions for use were on an inhalant medication for 1 of 1 resident (R15) whose inhalant medication was observed during medication administration. In addition, the facility failed to ensure 1 of 3 medication rooms medications stored for destruction were properly labeled.<br><br>Findings include | 21620 | | |

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| 21620 | Continued From page 79<br><br>R15's Physician Order report dated 2/22/17-3/22/17, included an order for Advair Diskus (combination steroid/bronchodilator) 250-50 micrograms (mcg)/dose: 1 puff inhalation twice a day for chronic obstructive pulmonary disease.<br><br>On 3/22/17, at 9:05 a.m. licensed practical nurse (LPN)-A was observed to hand an unlabeled Advair Diskus inhaler to R15. R15 administered a puff and inhaled the medication. LPN-A handed R15 a plastic cup containing UTI Stat (nutrient for urinary tract health) 30 milliliters (ml) and water and directed R15 to take a drink. R15 was observed to take two sips and swallow the fluid. LPN-A did not offer or suggest R15 swish/rinse the mouth.<br><br>On 3/22/17, at 9:11 a.m. the manufacturer's Medication Guide and Instructions for use in the Advair Diskus packaging was reviewed with LPN-A. The Medication Guide and Instructions for Use directed the user to rinse mouth with water without swallowing/spit after using Advair Diskus to help reduce the chance of getting oral thrush (a fungal infection). LPN-A confirmed she had not offered or provided R15 a mouth rinse/spit after the use of the medication. LPN-A confirmed the Advair Diskus lacked a prescription label and directions for use. LPN-A stated the Advair Diskus came in a manufacturer's package, which was in a Ziploc bag containing the prescription label. The Ziploc bag was in the manufacturer's boxed package which also contained the prescription label and the directions for use. LPN-A stated staff threw the packaging away and | 21620 | | |

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| 21620 | Continued From page 80<br>just keep the inhaler. LPN-A stated if the packaging was available the directions for use would have prevented me from providing a drink versus rinse/spit.<br><br>-at 9:27 a.m. registered nurse (RN)-A confirmed the Advair Diskus prescription label with instruction for use should have been on the inhaler or the Advair Diskus should have been stored in the prescription labeled packaging. RN-A confirmed she revised the medication administration record directing staff to provide rinse and spit according to manufactures directions.<br><br>On 3/23/2017, at 1:30 p.m. during tour of the medication storage room on the secured unit with RN-B. A clear plastic specimen Ziploc bag was observed in the medication destruction bin. RN-B confirmed the Ziploc bag contained approximately 100 round pink tablets and 87 white scored tablets following counting. RN-B confirmed there were no identifiable information on the medications and stated she did not know what the medications were, who they were for, or why they were in the destruction bin. RN-B confirmed medications were left in containers or cards they came in until the nurse responsible for medication destruction completed the task.<br><br>On 3/23/17, at 2:05 p.m. the director of nursing (DON) confirmed a prescription label with indications for use should be on or with all medications and medications for destruction should be in appropriately labeled containers until destruction. The DON confirmed the facility medication destruction program required revision. | 21620 | | |

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| 21620 | Continued From page 81<br><br>The Pharmacy Services Medication Labels policy, revised 6/2015, indicated medications were labeled in accordance with facility requirements and state and federal laws.<br><br>The Med (medication) Destruction policy, reviewed 4/2015, indicated the LPN'S would destroy medications (other than scheduled narcotic) that could not be returned to pharmacy via our incinerating program. Located on each wing in the medication room would be a gallon size container for pills and for cream/inhalers. The nurses would log these medications on the med destruction sheet and would place the meds in the containers. Once these containers were full, pharmacy would remove them and they would be incinerated per their protocol.<br><br>A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that all medications are labeled and stored properly. Education could be provided to all staff and monitoring systems could be developed to ensure ongoing compliance. The findings could be reported to the Quality Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 21620 | | |
| 21995 | MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults | 21995 | | |

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| 21995 | Continued From page 82<br><br>Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to immediately report potential abuse/mistreatment and/or neglect to the State agency (SA) for 1 of 3 residents (R64) who sustained fractures from an unwitnessed fall.<br><br>Findings include:<br><br>R64's quarterly Minimum Data Set (MDS) dated 12/20/16 indicated R64 had severe cognitive impairment and diagnoses which included Alzheimer's disease, depression, bipolar disorder, anxiety disorder and psychotic disorder. The MDS also indicated R64 exhibited fluctuating inattention symptoms of delirium and daily wandering behavior. The MDS further indicated R64 required extensive assistance of one staff for bed mobility, transfer, dressing, toilet use, and personal hygiene and required limited assistance of one person for ambulation and locomotion on the unit. | 21995 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 21995 | Continued From page 83<br><br>R64's Fall Assessment dated 3/2/17, indicated on 3/2/17, at 2:05 a.m. R64 had a fall in the bathroom by the TV room. The Assessment indicated R64 had been left alone on the toilet when the nursing assistant (NA) obtained a brief from R64's room. When the NA returned to the TV room bathroom, R64 was found face down on the floor. R64 was sent to the emergency room for an evaluation and was found to have a fractured nose and wrist. The Assessment included the question "Does this fall appear to constitute abuse or neglect of a vulnerable adult?" A choice of "No" was circled. The Assessment directed notification of the SA for a "Yes" response. In addition, the Assessment indicated the fall was reviewed by the fall committee on 3/2/17, and report to the SA was not indicated.<br><br>Review of Vulnerable Adult (VA) reports from October 2016, through March 2017, lacked a report for R64's fall with serious injury.<br><br>On 3/22/17, at 1:03 p.m. director of nursing (DON) and registered nurse (RN)-B confirmed R64's fall on 3/2/17, was unwitnessed.<br><br>On 3/23/17, at 3:08 p.m. the administrator and director of nursing (DON) confirmed R64's fall with fractures was not immediately reported to the SA, as required. The DON stated she was not aware a fall with serious injury was required to be reported.<br><br>The Assessment After a Fall policy dated 4/2015, directed all falls would be reviewed by the Fall | 21995 | | |

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| | 00017 | A. BUILDING: _____ B. WING _____ | 03/23/2017 |

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| 21995 | Continued From page 84<br>Committee on a daily basis and reports would be filed to the SA, if indicated.<br><br>The Abuse Prevention/Prohibition Program policy dated 11/20/16, indicated fractures were possible indicators of abuse or neglect that should be promptly reported. The policy also identified an injury should be classified as an injury of unknown origin when both the source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further directed allegations of abuse, neglect, suspicious injury of unknown origin and misappropriation of resident property would be reported immediately to the SA.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator could educate all staff on policies and procedures regarding alleged reports of mistreatment. The administrator could develop a monitoring system to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21995 | | |
| 22000 | MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults<br><br>Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and | 22000 | | |

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| 22000 | Continued From page 85 | 22000 | | |

personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by

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| 22000 | Continued From page 86<br>another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to operationalize their abuse policy and procedures related to the immediate reporting of potential abuse/mistreatment or neglect to the State agency (SA) for 1 of 3 residents (R64) reviewed for abuse prohibition who had a fall with serious injury.<br><br>Findings include:<br><br>The Abuse Prevention/Prohibition Program policy dated 11/20/16, Identification section indicated a fracture as a possible indicator of abuse or neglect which should be promptly reported. The Investigation section indicated the facility would evaluate injuries of unknown origin as a possible indicator of abuse, neglect or maltreatment warranting the need for further investigation. Injuries of unknown origin would be classified as an injury of unknown origin when both the source of the injury was not observed by any person or the source of the injury could not be explained by the resident, and the injury was suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy further indicated an investigation would normally be conducted by the | 22000 | | |

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| 22000 | Continued From page 87<br>administrator or director of nursing (DON) or designee. Staff were directed to promptly report any incident or suspected incident of resident abuse or neglect including suspicious injuries of unknown origin and to report internally to allow the facility to begin to initiate an investigation, and report allegations immediately to the State agency, as required.<br><br>R64's quarterly Minimum Data Set (MDS) dated 12/20/16, indicated R64 had severe cognitive impairment and diagnoses which included Alzheimer's disease, depression, bipolar disorder, anxiety disorder and psychotic disorder. The MDS also indicated R64 exhibited fluctuating inattention symptoms of delirium and daily wandering behavior. The MDS further indicated R64 required extensive assistance of one person for bed mobility, transfer, dressing, toilet use, and personal hygiene and required limited assistance of one person for ambulation and locomotion on the unit.<br><br>R64's Fall Assessment dated 3/2/17, indicated R64 had a fall in the bathroom by the TV room at 2:05 a.m. on 3/2/17. The Assessment indicated R64 had been left alone on the toilet when the nursing assistant (NA) obtained a brief from R64's room. When the NA returned to the TV room bathroom, R64 was found face down on the floor. The assessment also indicated the fall resulted in an emergency room visit where R64 was found to have a fractured nose and wrist. The Assessment included the question "Does this fall appear to constitute abuse or neglect of a vulnerable adult?" A choice of "No" was circled. The Assessment directed notification of the SA | 22000 | | |

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| 22000 | Continued From page 88<br>for a "Yes" response. In addition, the Assessment indicated the fall was reviewed by the fall committee on 3/2/17, and report to the SA was not indicated.<br><br>Review of Vulnerable Adult (VA) reports from October 2016 through March 2017 lacked a report for R64's fall with serious injury.<br><br>On 3/22/17, at 1:03 p.m. the DON and registered nurse (RN)-B confirmed R64's fall on 3/2/17, was unwitnessed.<br><br>On 3/23/17, at 3:08 p.m. the administrator and DON confirmed R64's fall with fractures was not immediately reported to the SA as required. The DON stated she was not aware a fall with serious injury was required to be reported.<br><br>SUGGESTED METHOD OF CORRECTION: The administrator could develop policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator could educate all staff on those policies and procedures. Theadministrator could develop a monitoring system to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 22000 | | |