MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 917D
Facility ID: 00761

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245521**

2. STATE VENDOR OR MEDICAID NO.
(L2) **785540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL TODD COUNTY CARE CENTER**
(L4) **406 EAST HIGHWAY 71, PO BOX 38**
(L5) **CLARISSA, MN** (L6) **56440**

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 **03/03/2017** (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)
09/30

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

12. Total Facility Beds **60** (L18)

13. Total Certified Beds **60** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program
Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(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 :
Brenda Fischer, Unit Supervisor 03/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/27/2017 (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
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/14/2017
(L33)

Posted 03/28/2017 Co.

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245521
March 27, 2017

Mr. Jason Polovick, Administrator
Central Todd County Care Center
406 East Highway 71, Po Box 38
Clarissa, MN 56440

Dear Mr. Polovick:

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 February 3, 2017 the above facility is certified for or recommended for:

60 Skilled Nursing Facility/Nursing Facility Beds

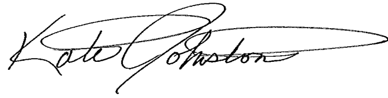
Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 24, 2017

Mr. Jason Polovick, Administrator
Central Todd County Care Center
406 East Highway 71, P.O. Box 38
Clarissa, MN 56440

RE: Project Number S5521026

Dear Mr. Polovick:

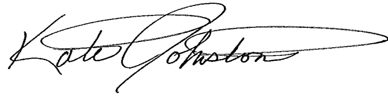
On January 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 3, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 3, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2017, effective February 3, 2017 and therefore remedies outlined in our letter to you dated January 20, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245521	A. Building B. Wing	3/3/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0166 Reg. # 483.10(j)(2)-(4) LSC	Correction Completed 02/03/2017	ID Prefix F0242 Reg. # 483.10(f)(1)-(3) LSC	Correction Completed 01/12/2017	ID Prefix F0279 Reg. # 483.20(d);483.21(b)(1) LSC	Correction Completed 01/06/2017
ID Prefix F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 01/09/2017	ID Prefix F0318 Reg. # 483.25(c)(2)(3) LSC	Correction Completed 01/09/2017	ID Prefix F0465 Reg. # 483.90(i)(5) LSC	Correction Completed 01/13/2017
ID Prefix F0520 Reg. # 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) LSC	Correction Completed 02/03/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 03/24/2017	SIGNATURE OF SURVEYOR 10562	DATE 03/03/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/5/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 917D
Facility ID: 00761

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245521**

2. STATE VENDOR OR MEDICAID NO. (L2) **785540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL TODD COUNTY CARE CENTER**
(L4) **406 EAST HIGHWAY 71, PO BOX 38**
(L5) **CLARISSA, MN** (L6) **56440**

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 **01/05/2017** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **60** (L18)

13. Total Certified Beds **60** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(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 :
Mardelle Trettel, HFE NE II 02/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/13/2017 (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 **02/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS
Posted 02/14/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 20, 2017

Mr. Jason Polovick, Administrator
Central Todd County Care Center
406 East Highway 71, PO Box 38
Clarissa, Minnesota 56440

RE: Project Number S5521026

Dear Mr. Polovick:

On January 5, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> Opportunity to Correct - **the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> Electronic Plan of Correction - **when a plan of correction will be due and the information to be contained in that document;**
>
> Remedies - **the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> Potential Consequences - **the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

<u>Informal Dispute Resolution</u> - **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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 14, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 April 5, 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 July 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

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

Sincerely,

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING ______ B. WING ______	01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/3/17 to 1/5/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Central Todd County Care Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The	F 166		2/3/17

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

Electronically Signed — 02/01/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING ______ B. WING ______	01/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL TODD COUNTY CARE CENTER	**406 EAST HIGHWAY 71, PO BOX 38 CLARISSA, MN 56440**

(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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grievance policy must include:

(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately

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F 166	Continued From page 2 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act on concerns of cool temperatures in the main dining room for 3 of 3 residents (R18, R20 and R15) who complained of being cold during meal time.	F 166	Residents R18, R20 and R15 have complained of cool temperatures in the dining room on past occasions. Offers to move or rearrange the cold residents have been made, but were declined, as those residents like sitting by the window.	

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F 166	Continued From page 3 Finding include: R20's quarterly Minimum Data Set (MDS) dated 11/4/16 indicated he was moderately cognitively impaired. The MDS also indicated R20 was able to express ideas and wants, and made himself understood. R18's significant change MDS dated 9/23/16 indicated R18 was cognitively intact, and was able to express ideas and wants, and made himself understood. R15's quarterly MDS dated 10/19/16 indicated R15 was cognitively intact. The MDS indicated he was usually understood, had difficulty communicating some words and finishing thoughts, but was able if prompted or given time. During observation of the noon meal in the main dining room on 1/3/17 at 12: 22 p.m., R18 sat at a table along with R20 and R15. The table was located about 4' (feet) from a north side wall, and in front of a double-pane picture window, about 6' wide by 5' in height. R18, was wearing a sweater, and sat with his back to the window. Left of the window was an 3' wide exit metal and glass door, and a cold draft was felt in front of the door. Also, above the tables along the wall, above where R18, R15 and R20 sat, were heat vents, which also emitted a cool draft. During an interview on 1/3/17 at 12:38 p.m., R20 stated he usually sits in front of the window (in the main dining room) and even with the shade pulled down, "its damn cold, and I don't like it." R20 stated, it was "always cold" in the dining room and added they forgot to turn off the AC (air conditioning) today. R20 stated staff were aware	F 166	During the survey observations, the highest recorded outside temperature was 3 degrees F and the lowest was -21.9 degrees F. The lowest dining room temperature (continuously recorded) during any meal services was 71.6 degrees. Upon further investigation it was found that during times of adequate room temperature, while the HVAC was not actively heating, fresh air was being provided through the ductwork as needed for environmental engineering specifications. This fresh air was passively being heated, but could feel cool when exiting the HVAC system to those sitting directly under the ducts. The system programming has been updated to heat the fresh air to match the ambient temperature of the room. R18, R20 and R15 were interviewed and declined the offer to move. All three also said the modification improved the temperature. Temperatures will be monitored daily and affected resident interviews will be conducted weekly to ensure correction. Dining room environmental conditions, resident interviews and any changes made will be reviewed in the QAU meetings. Overall Responsibility: Maintenance Supervisor	

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of his complaint of the cold dining room.

In an interview on 1/4/17 at 6:53 p.m., R18 stated when he goes to the dining room, he has to put on another sweater. "It helps, but it's still too cold." R18 stated it had been really cold this winter, especially if there was a south wind. R18 stated he has mentioned his concern about the cold temps to staff in the dining room, and they are well aware of it.

During an interview of 1/5/17 at 8:00 a.m., R15 stated the dining room temperature seemed to always be cold, it comes right out of the vent. "It's always cold for me." R15 stated he believed the staff knew about the concern with the cold dining room.

During an interview on 1/5/1 at 1:43 p.m., the maintenance supervisor (MS) stated the temperatures in all rooms and parts of the building were checked daily. The MS stated the common areas, like the main dining room were set at 72 deg F (degrees Fahrenheit).

On 1/5/17 at 1:43 p.m., with the MS and in presence of the surveyor, the computer-monitored temperature indicated the main dining room temperature was 72.0 deg F. During the same interview, the MS stated he spoke with the administrator about placing plastic on the windows by the dining area, but thought this would not work and did not implement this. The MS stated they could just move the residents from the area, since there was plenty of space in the dining room. The MS stated he was aware that residents had expressed discomfort from the cooler temperatures, but they had not done anything to alleviate this complaint.

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	In an interview on 1/5/17 at 3:15 p.m., the director of nursing (DON) stated she and the administrator talked about the window, and the "temps" (temperature) in the dining room. The DON stated she had not heard any specific complaints, but was aware of the problem by the window. The DON stated she did not know if the dietary manager asked anyone about moving or doing some other seating arrangements. The DON acknowledged the dining room can be uncomfortable and stated we'll have to do something.			
	During an interview of 1/5/17 at 3:20 p.m., the administrator stated we could make a change, and change the resident order around in the dining room. The administrator stated it was hard to please everyone, especially when you have residents who've made a choice to sit by the window, but I guess we can make a change.			
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		1/12/17
	(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.			
	(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.			
	(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the			

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F 242	Continued From page 6 facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop an individualized rising routine to meet the needs for 1 of 1 residents (R35) with severe cognitive impairment and who was observed to be fully dressed while in bed. Findings include: R35's significant change Minimum Data Set (MDS) dated 11/16/16, identified R35 had severe cognitive impairment and was totally dependant on staff for dressing and bed mobility. The MDS identified R35 is rarely or never understood. During observation on 1/5/17, at 7:21 a.m. nursing assistant (NA)-A was in the "B" wing and told NA-B, "Do you want to get [R35] up now?" NA-A paused and then stated, "She's [R35] all ready to go." At 7:47 a.m. (16 minutes later) NA-A and NA-B entered R35's room to assist her with morning cares. R35's eyes were closed and she did not respond verbally when spoken to by the NA staff. R35's bedding was pulled back exposing R35 whom was already dressed in a pink adaptive sweater and pink pair of pants with a hoyer sling placed underneath of her. R35 was then assisted to transfer out of the bed into her wheelchair using a mechanical lift, and brought to the dining room for breakfast at 7:54 a.m. R35's Comprehensive Activity Assessment dated 11/17/16, identified R35 was not orientated to person, place or time, and had poor vision and	F 242	Reviewed all current residents who cannot safely or competently communicate their wishes or needs to staff. Guardians, agents or resident representatives were contacted with questionnaire regarding resident’s desires. Information received was used to update resident’s plan of care for all affected residents. A policy “Resident preferences policy” was generated to assist staff in acquiring resident preferences and integrating them in to the plan of care. Staff responsible for interviewing and documenting resident preferences have been educated on the new policy and expectation to document resident preferences. QAU will review Care Plans of all new residents with limited or inability to make their preferences known on a quarterly basis to ensure compliance. Overall Responsibility: Resident Services Director	

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F 242	Continued From page 7 hearing. The assessment contained a section labeled, "Daily Interview Preference," and listed a question asking if the interview should be conducted. This question was answered, "No" with a primary respondent for the assessment being marked, "No response or non-responsive." A further section labeled, "Staff assessment," was completed with R35 being identified to prefer different activities such as snacks between meals, listening to music, and being around animals. The assessment lacked any indication of R35's preferred morning rising routine, including getting dressed and remaining in bed until staff assisted her. R35's care plan dated 11/22/16, identified a focus section of, "Daily Preferences," and listed several interventions which included a preferred bedtime and bathing schedule. The care plan lacked any identified preferences to be dressed and left in bed until a later time. When interviewed on 1/5/17, at 7:56 a.m. NA-A stated she had washed and dressed R35 at 6:30 a.m. but left her in bed dressed because she thought it would, "Be good to sleep in." Further, NA-A stated she was unsure if R35 liked being washed up or dressed and left in bed, and always kept her eyes and does not respond. During interview on 1/5/17, at 8:45 a.m. NA-B stated NA-A had asked for help earlier in the morning to assist R35 out of bed, however NA-B was unable to assist her so R35 was just left in bed dressed. NA-B stated R35 used to like to sleep in when she was more verbal and able to communicate her wishes, however, if already awake, would then allow staff to wash and dress her. She was unsure if R35 was awake before	F 242		

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NA-A got her dressed.

R35's medical record was reviewed and lacked any assessment to determine what R35's preferred rising time or routine was. There was no indication if the facility asked R35's family to determine what R35's preferences were.

When interviewed on 1/5/17, at 3:19 p.m. registered nurse (RN)-A stated resident choices and preferences were assessed on admission and documented in the care plan adding if a care plan lacked any information on a preference, but there were no preferences identified. RN-A stated R35 was unable to verbally communicate her wishes, needs or preferences of getting dressed at 6:30 a.m. which, "Seems a little bit early for her." RN-A stated she was unaware if R35 choices or preferences had been identified, or if the family had been asked to identify her preferences.

During subsequent interview on 1/5/17, at 3:51 p.m. RN-A stated she had reviewed R35's medical record and was unable to locate any information about R35 preferred or liked being dressed and left in bed. RN-A stated staff, "Shouldn't be doing it," as, "It might be something she doesn't want." Further, RN-A stated she had spoken with other staff in the facility, and nobody had ever contacted R35's family to obtain their input to her past preferences for rising, especially since R35 was unable to communicate her wishes or needs anymore.

A facility policy on assessment of daily preferences and choices was requested, but none was provided.

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F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (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. 483.21 (b) Comprehensive Care Plans (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 - (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 (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). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 279		1/6/17

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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.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(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 local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to develop a comprehensive care plan which included specific interventions for resident behaviors/mood status for 2 of 2 residents (R15, R48) reviewed who were on an antidepressant. Further, the facility failed to develop and identify a restorative program on the care plan for 1 of 5 residents (R15) who received range of motion (ROM) in the facility.

Findings include:

ANTIDEPRESSANT MEDICATION

R15's 30 day scheduled Minimum Data Set

F 279

This citation reflects two separate issues in regards to care plan development, those surrounding mood and behavior within the care plan when residents were on antidepressant medications and development of care plans with respect to restorative nursing programs.
Mood/Behavior
Updated care plan for both residents identified in the citation (R15, R48) to included mood and behavior focus.
Reviewed all remaining residents on an antidepressant or demonstrating mood or behavior issues and added mood and behavior focuses to their plan of care.

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(MDS), dated 9/12/16 identified R15 had moderate cognitive impairment. R15's current diagnosis list identified a new diagnosis of "major depressive disorder, single episode, unspecified," dated 9/13/16.

R15's PHQ-9 (a tool used to evaluate depression symptoms), dated 9/12/16, identified R15 had experienced little interest or pleasure in doing things, felt down, depressed, or hopeless and experienced feeling tired or having little energy, "12-14 days" during the two week period.

R15's current physician orders, dated 12/7/16, identified R15 had active orders for, Cymbalta (an antidepressant medication) 60 mg (milligrams) once a day for depression which was started on 9/13/16.

R15's care plan, dated 10/25/16, identified R15 had impaired cognition with varying confusion, forgetfulness and dementia. The care plan did not identify R15 had a depressed mood, hopelessness, little energy or used an antidepressant. There were no specific interventions identified for staff to implement to help decrease or elevate R15's depressed mood and hopelessness.

During interview on 1/5/17, at 7:49 a.m. nursing assistant (NA)-C stated R15 used to have depressed mood, but further states she thought "it has gotten better."

During interview on 1/5/17, at 11:58 a.m. registered nurse (RN)-A stated the physician's dictation from 9/13/16 indicated an order for Cymbalta for moderate depression and left leg pain. RN-A further stated R15 had "seemed

RN Care Coordinator to review daily documentation regarding new mood/behavior or medications to address required plan of care changes.
Restorative Nursing
Reviewed and updated the restorative program for R15 on residents Plan of Care.
Reviewed and updated restorative programs and Care plans as needed on all remaining residents.
New residents will have restorative programs documented on plan of care during normal development cycles.
Staff Education provided to licensed nursing staff. Correction plan disseminated to all other direct care staff.
Care plans will be reviewed for accuracy/compliance and a quarterly basis, and QAU will review the results of the Care Plan reviews and suggest modifications as necessary.
Overall responsibility: Director of Nursing.

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down." RN-A reported R15's care plan should contain a mood focus, address the Cymbalta, and contain interventions for depression symptoms, which was missing.

During interview on 1/5/17, at 3:11 p.m. the director of nursing (DON) stated a mood focus along with behaviors were expected to be on the care plan.

R48's quarterly MDS dated 12/1/16, identified R48 had severe cognitive impairment and depression.

R48's physician orders dated 1/5/17, identified R48 had active orders for, Celexa (antidepressant medication) 10 mg by mouth one time a day for major depressive disorder, single episode, with a start date of 9/27/16.

R48's PHQ-9 (a tool used to evaluate depression symptoms) dated 12/1/16, identified R48 experienced feeling tired and having little energy, "12-14 days" during a two week period. Further, R48 was identified as having, "Minor Depressive Syndrome," on the assessment.

R48's Psychiatric Progress Note dated 12/21/16, identified R48 was followed to, "...establish psychiatric care and manage psychotropic's [medications]." The note identified R48 had her Celexa reduced and was, "more animated and she is more social with other residents." Further, the note included a treatment plan which include, "Staff to continue to use psychosocial, interpersonal and environmental interventions to

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manage behaviors."

R48's care plan dated 12/6/16, identified R48 had impaired cognition with short and long term memory loss, however lacked any information about R48's feeling tired, having little energy or the use of an antidepressant medication. There were no specific interventions identified for staff to implement to help reduce or elevate R48's identified symptoms of depression.

During interview on 1/5/17, at 1:41 p.m. NA-A stated R48 was typically a, "Sweet lady," however, at times would become depressed and weepy. NA-A stated she was unaware of any specific interventions to help R48 when she is depressed besides just providing reassurance or offering to take her to activities.

When interviewed on 1/5/17, at 2:16 p.m. registered nurse (RN)-A stated R48 had been, pretty withdrawn for awhile, but was doing better while taking the ordered Celexa. RN-A reviewed R48's care plan and stated her use of antidepressant medication or any specific interventions to help her depression were not identified. There should be a mood focus and there is not. Further, RN-A stated R48's history of depression and use of psychotropic medications should be identified on her care plan.

RESTORATIVE PROGRAM:

R15's quarterly MDS, dated 10/19/16, identified no cognitive impairment and needed extensive assistance with mobility and transfers, and had a functional limitation of the lower extremity on one side.

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R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as he tolerated or would agree to. R15's restorative program included using the NuStep (exercise bike), and performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.

R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated the "left leg continues to be stiff and slower with movement." R15 was not able to completely flex or extend the leg but was on a Nursing Rehab program for exercises.

R15's current care plan, dated 10/25/16, identified R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions; however, it did not identify R15 was on a restorative program or at times he refused restorative exercises, even though the restorative plan had been in place since 9/17/16.

During interview on 1/5/17, at 1:13 p.m. RN-C stated care plans were updated on admission and quarterly with assessments; however, since R15's restorative program was started in between his admission and quarterly assessments, the care plan had not been updated. RN-C stated it "was an error." RN-C further reported R15's care plan did not identify he refused the restorative program at times, and should be identified.

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F 279	Continued From page 15 A facility Resident Assessment and Interdisciplinary Care Planning policy dated 11/2016, identified a comprehensive assessment should be completed and , "All problems and potential problems identified in this assessment are documented by entering a focus statement on the Care Plan." Further, the policy directed each identified problem should, " ... be incorporated into the Care Plan which identifies goals, approaches, target dates of completion, and assigned responsibilities."	F 279		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative programs were implemented as directed by the care plan for 4 of 5 residents (R5, R35, R29, and R12) reviewed for range of motion services. Findings include: R5's diagnoses, as identified on the significant change Minimum Data Set (MDS) dated 10/13/16, included pain in left hip, anemia and Alzheimer's dementia. The MDS also indicated R5 required extensive assistance for bed mobility,	F 282	Redesigned and implemented restorative nursing program for all residents, including the organization and prioritization of staffing towards execution of restorative programming activities. New programming began 1-9-2017. Direct care staff educated on new program and responsibilities. Program documentation will be reviewed/ audited on a weekly basis and corrections and adjustments to the program will be made as needed. QAU will review weekly audit/review documentation for	1/9/17

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F 282	Continued From page 16 transferring and dressing, and was cognitively impaired. R5's care plan, revised 10/7/2016, identified an activity of daily level (ADL) self-care deficit, related to pain, history of left hip fracture, and included the intervention of a restorative program. R5's Restorative Care Program, included the following directions: 10 times 1-2 pound free weights on bilateral, upper extremities, flex and extend elbow, punch out and internal rotation; sit and use upper extremity bike 5 minutes, with rest as needed; overhead pulley with no weight 3 to 4 minutes; daily walk 60 feet; and NuStep (seated, exercise machine) level one for 10 minutes. During observation on 1/5/2017, at 7:13 a.m. nursing assistant (NA)-D provided R5 with morning cares, and also assisted R5 to transfer from the bed into her wheelchair. There was no restorative services provided during the provision of morning cares for R5. In an interview on 1/5/17, at 7:50 a.m. NA-D stated she did not today, nor routinely, work on restorative programs, but was sure R5 had one. NA-D stated there were other aides who did the rehab programs. Review of the Facility Nursing Rehab sheets from July 2016 to November 2016 were reviewed. The documentation indicated R5's restorative services were provided/refused or unavailable as follows: July, 5x (times), 1x refused; August, 3x, 1x refused, 2 x unavailable; September, 5x, 1x refused; October, 6x, 4x refused; November 3x, 2x refusals, 1x unavailable; there was no documentation after November 15th; December: no documentation; and January 2017: no	F 282	compliance to plan and recommend modifications as necessary. Overall responsibility: Director of Nursing	

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documentation.

During an interview on 1/5/2017, at 2:06 p.m. nursing assistant (NA)-B stated she was one of the rehab aides, and she "dutifully" completed restorative nursing programs with residents. NA-B stated that about November, however, there were no staff available to complete the programs, and she was often "pulled" from rehab assignments to work on the floor, as often as five times a week. NA-B stated R5's restorative goal was five times a week, but "it just didn't get done." NA-B stated it was no surprise there was little or no documentation of the rehab program for R5 since the middle of November.

In an interview on 1/5/17, at 2:58 p.m. the director of nursing (DON) stated the Restorative Care Program was part of R5's comprehensive care plan, and it was nursing's responsibility to make sure the program was followed. The DON acknowledged R5's restorative program was not consistently completed for several months, and also lacked documentation that R5's program was completed at all since mid-November. The DON stated she "absolutely" expected R5's, and other residents' care plans be followed, and the restorative nursing programs be completed.

R35's significant change MDS dated 11/16/16, identified R35 had severe cognitive impairment, was totally dependent on staff for her activities of daily living (ADLs), and had impaired functional range of motion (ROM) on both of her upper and lower extremities.

R35's care plan dated 11/22/16, identified R35 had an alteration in ADLs and had, "Dependence

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F 282	Continued From page 18 on staff." Further, the care plan identified several interventions including, "Restorative Program." R35's Restorative Care Program dated 7/1/15, identified R35 had right sided upper and lower extremity weakness due to a stroke, and listed a goal of her program as, "Maintain current ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated," with a frequency of "7x/wk [times per week]." On 1/3/17, at 1:27 p.m. R35 was laying in bed with her eyes closed. During subsequent observation on 1/4/17, at 12:32 p.m. R32 was seated in a reclining wheelchair with her eyes closed. There was no observed ROM completed by staff during these times. During observation of morning care on 1/5/17, at 7:47 a.m. nursing assistant (NA)-A and NA-B assisted her with rising and seated her in her wheelchair. No ROM was completed on R35's upper or lower extremities during the morning care. During interview on 1/5/17, at 8:45 a.m. NA-B stated stated R35 was supposed to have ROM completed daily, however, it was not being done, "Due to not having full staff." NA-B stated R35 had not had ROM completed as directed by her program for over a month, and R35's contractures were, "progressively getting worse," and R35 seemed, "Tighter," when staff completed cares. NA-B stated the staff tracked participation with the ROM programs on a flowsheet by signing their initials when it was done, or a, "X" symbol	F 282		

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when it was not completed.

R35's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R35 had ROM completed four times, with a, "X" being written in 26 times on the remaining days.

October 2016: R35 had ROM completed seven times, with a, "X" being written in 23 times on the remaining days. R35 was identified as refusing the ROM once.

November 2016: R35 had ROM completed four times, with a, "X" being written in 12 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

When interviewed on 1/5/17, at 9:20 a.m. registered nurse (RN)-B stated R35 was on a restorative nursing program for her arm contractures and should have ROM completed to her arms daily, "To maintain their current range of motion and prevent further contractures."

R29's quarterly MDS dated 11/11/16, identified R29 had severe cognitive impairment, was totally dependent on staff for her ADLs, and had

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impaired functional range of motion (ROM) on both of her upper extremities.

R29's care plan dated 11/21/16, identified R29 had self care performance deficit with a left hand contracture. The care plan directed staff with interventions including, "Restorative Rehab Program."

R29's Restorative Care Program dated 5/18/15, identified a goal to, "Maintain ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated by resident," with a frequency of "7x/wk."

R29's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R29 had ROM completed eight times, with a, "X" being written in 22 times on the remaining days.

October 2016: R29 had ROM completed 12 times, with a, "X" being written in 19 times on the remaining days.

November 2016: R29 had ROM completed five times, with a, "X" being written in 11 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate

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F 282	Continued From page 21 any ROM had been attempted or completed after 11/16/16. R12's quarterly MDS dated 9/14/16, identified R12 had moderate cognitive impairment, required extensive assistance with ADLs, and had impaired functional ROM on both of his upper and lower extremities. R12's care plan dated 12/19/16, identified R12 was at risk for falls related to impaired mobility and balance, and directed staff to complete a, "Restorative Program." R12's Restorative Care Program dated 12/16/16, identified a diagnosis of, Joint limitation of movement, and listed a goal to, Maintain R U/E [right upper extremity] function for self feeding. The sheet provided a space labeled, Approaches/Recommendations for Implementation of Above Goals, and directed staff to complete, "AAROM [active assisted range of motion] R [right] shoulder," and listed several instructions for staff to follow using weights with R12's flexion and extension exercises. Further, the program identified the restorative program should be completed 4 times a week. R12's Nursing Rehab forms were requested, however none were provided to demonstrate the restorative program had been attempted or completed since being implemented on 12/16/16. During interview on 1/5/17, at 2:09 p.m. RN-A stated a care plan was used to ensure residents are, "Getting their needs met," and staff were expected to implement them or update the nurses	F 282		

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F 282	Continued From page 22 so interventions could be revised and addressed. Further, RN-A stated residents should have had their restorative programs completed as directed to, "Prevent further loss," of their mobility. A facility Resident Assessment and Interdisciplinary Care Planning policy dated 11/2016, identified a comprehensive assessment should be completed and , "All problems and potential problems identified in this assessment are documented by entering a focus statement on the Care Plan." Further, the policy directed each identified problem should, " ... be incorporated into the Care Plan which identifies goals, approaches, target dates of completion, and assigned responsibilities."	F 282		
F 318 SS=E	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing programs to ensure functional range of motion was maintained for 5 of 5 residents (R35, R5, R15, R29, and R12) reviewed for range of	F 318	Redesigned and implemented restorative nursing program for all residents, including the organization and prioritization of staffing towards execution of restorative programming activities.	1/9/17

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F 318	Continued From page 23 motion services. Findings include: R35's significant change MDS dated 11/16/16, identified R35 had severe cognitive impairment, was totally dependent on staff for her activities of daily living (ADLs), and had impaired functional range of motion (ROM) on both of her upper and lower extremities. R35's care plan dated 11/22/16, identified R35 had an alteration in ADLs and had, "Dependence on staff." Further, the care plan identified several interventions including, "Restorative Program." R35's Restorative Care Program dated 7/1/15, identified R35 had right sided upper and lower extremity weakness due to a stroke, and listed a goal of her program as, "Maintain current ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated," with a frequency of "7x/wk [times per week]." Further, the program identified R35 had been discharged from hospice care on 11/14/16. During observation on 1/4/17, at 12:32 p.m. R35 was seated in a high-back reclining wheelchair in her room listening to the radio with her eyes closed. R35 had visible contractures of her shoulders, elbows and hands as she held her arms toward her upper chest. R35 had no visible splints or braces in place on her arms or hands, and no ROM was completed by staff at this time. During interview on 1/4/17, at 1:34 p.m. registered nurse (RN)-A stated R35 was, "kinda	F 318	New programming began 1-9-2017. Direct care staff educated on new program and responsibilities. Program documentation will be reviewed/ audited on a weekly basis and corrections and adjustments to the program will be made as needed. QAU will review weekly audit/review documentation for compliance to plan and recommend modifications as necessary. Overall responsibility: Director of Nursing	

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bent in the arms," and had contractures in her upper and lower extremities due to a stroke suffered years prior. Further, RN-A stated R35 did not use braces or splints, but received daily range of motion to help with her contractures.

During observation of morning care on 1/5/17, at 7:47 a.m. nursing assistant (NA)-A and NA-B assisted her with rising and seated her in her wheelchair. No ROM was completed on R35's upper or lower extremities during the morning care.

When interviewed on 1/5/17, at 7:56 a.m. NA-A stated she typically helps R35 get ready a, "Couple times a week," and does not ever complete ROM or exercises with R35. NA-A stated she was not aware if R35 was on a restorative nursing program, but added, "She's very stiff," when staff are helping her dress. Further, NA-A stated the facility had a couple other NA staff responsible to complete the restorative programs, however, when the facility is short staffed, those aides are pulled to the floor, "We don't do rehab when we are short on the floor."

During interview on 1/5/17, at 8:45 a.m. NA-B stated she was one of two NA staff responsible to complete the restorative programs for residents. NA-B stated R35 was supposed to have ROM completed daily, however, it was not being done, "Due to not having full staff." NA-B stated R35 had not had ROM completed as directed by her program for over a month, and R35's seemed, "Tighter," when staff completed cares. NA-B stated the staff tracked participation with the ROM programs on a flowsheet by signing their initials when it was done, or a, "X" symbol when it

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was not completed. Further, NA-B stated she had reported these concerns to the occupational therapist (OT).

R35's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R35 had ROM completed four times, with a, "X" being written in 26 times on the remaining days.

October 2016: R35 had ROM completed seven times, with a, "X" being written in 23 times on the remaining days. R35 was identified as refusing the ROM once.

November 2016: R35 had ROM completed four times, with a, "X" being written in 12 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

When interviewed on 1/5/17, at 9:20 a.m. registered nurse (RN)-B stated R35 was on a restorative nursing program for her arm contractures and should have ROM completed to her arms daily, "To maintain their current range of motion and prevent further contractures." RN-B stated the restorative NA staff were responsible to complete the cares of each program, however, they were being pulled to the floor to work instead, "Two or three times a week, if not more."

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During interview on 1/5/17, at 1:09 p.m. OT-A stated it had been a few years, since R35 had been last seen by OT for any therapy services, however, added she had recently requested orders for R35 to be evaluated due to nursing staff reported R35 to have, "Some tightness in her elbows and wrists."

On 1/5/17, at 1:12 p.m. OT-A completed passive range of motion (PROM) to R35's upper extremities with the surveyor present. OT-A stated R35 had poor abduction (motion of the joint away from the body) in her left shoulder adding it was, "Very, very tight." OT-A stated R35 was, "Probably missing 35 to 45 degrees of extension," in her left elbow. Further, OT-A completed PROM to R35's right side and stated R35's right shoulder was better than her left side with, "About 20 degrees of abduction," and, "20 degrees of flexion [the action of bending]," however, added R35's right elbow was, "Minus 25 or 30 degrees."

When interviewed following the PROM on 1/5/17, at 1:25 p.m. OT-A stated she had not personally worked with R35 prior, so she was unable to determine if a decline in R35's ROM had occurred or not. Further, OT-A stated nursing staff should be completing the ROM exercises to help increase the circulation and potentially reduce R35's pain with dressing and other activities of daily living, "That is something that would be good to educate nursing staff on."

R5's diagnoses, as identified on the significant change Minimum Data Set (MDS) dated 10/13/16, included pain in left hip, anemia and

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F 318	Continued From page 27 Alzheimer's dementia. The MDS also indicated R5 required extensive assistance for bed mobility, transferring and dressing, and was cognitively impaired. A Range of Motion (ROM)/Balance Assessment, dated 12/28/2016, indicated R5 had difficulty touching behind her head, was able to reach to about shoulder height; was able to flex and extend right leg and foot and left hand. The assessment also indicated R5 had difficulty extending left leg, had pain and stiffness to leg, and that impairments to upper and lower left extremity affected R5's daily physical functioning. Further, R5 was able to stand from seated position with use of a grab bar, and completed surface to surface transfer independently. R5 received increased assistance from staff depending on pain and weakness. R5's Care Area Assessment (CAA) for activities of daily living (ADL's)/Rehabilitation Potential, dated 10/6/16, identified potential for decline in ADLs, and need for increased assistance from nursing staff. The CAA indicated the need for care planning to slow or minimize R5's decline, and to maintain current level of functioning. During observation of morning cares on 1/5/2017 at 7:13 a.m., nursing assistant (NA)-D dressed R5's lower body while still in bed. R5 was able to sit up with assistance, and required limited assistance to lift and move R5's legs to sit up at the side of the bed. While dressing, R5 was able to hold up her arms, slightly below shoulder level, as NA-D placed R5's hands and arms through the shirt arm holes. R5 did not exhibit any pain while dressing, and neither hands nor arms were contracted. NA-D also assisted R5 to transfer	F 318		

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from the bed into her wheelchair. With a gait belt in place, R5 grasped the left arm rest of the wheelchair next to the bed, and was able to stand with assistance. During the transfer, R5 was slightly hunched over, but able to bear her weight. NA-D assisted to support and maintain balance for R5 as she pivoted, then sat into her wheelchair. No restorative services were provided during morning cares.

In an interview on 1/5/17, at 7:50 a.m. NA-D stated R5 usually required "limited" assistance of one staff for transfers, and getting dressed, and also that R5's participation depended on her hip pain. NA-D stated she did today, nor routinely, work on restorative programs, but was sure R5 had one. NA-D stated there were other aides who did the rehab programs. NA-D also stated she has not seen R5 walk with staff in "more than a month."

R5's care plan, revised 10/7/2016, identified an ADL self-care deficit, related to pain, history of left hip fracture, and included the intervention of a restorative program.

R5's "Restorative Care Program," revised 11/16/15, indicated goals: maintain upper extremity strength and endurance to assist with activities of daily living; maintain lower extremity strength; maintain ability to ambulate; and maintain balance strategies. The program directed the following approaches: 10 times 1-2 pound free weights on bilateral, upper extremities, flex and extend elbow, punch out and internal rotation; sit and use upper extremity bike 5 minutes, with rest as needed; overhead pulley with no weight 3 to 4 minutes; daily walk 60 feet (revised 2/26/16); and NuStep (seated device)

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F 318	Continued From page 29 level one for 10 minutes. Nursing Rehab sheets from July 2016 to November 2016 were reviewed and indicated R5's restorative services were provided/refused or unavailable as follows: July, 5x (times), 1x refused; August, 3x, 1x refused, 2 x unavailable; September, 5x, 1x refused; October, 6x, 4x refused; November 3x, 2x refusals, 1x unavailable; there was no documentation after November 15th. There was no documentation for December 2016 or January 2017. During an interview on 1/5/2017, at 2:06 p.m. nursing assistant (NA)-B stated she was one of the rehab aides, and she "dutifully" completed restorative nursing programs with residents. NA-B stated that about November, however, there were no staff available to complete the programs, and she was often "pulled" from rehab assignments to work on the floor, as often as five times a week. NA-B stated R5's restorative goal was five times a week, but "it just didn't get done." NA-B stated it was no surprise there was little or no documentation of the rehab program fro R5 since the middle of November. In an interview on 1/5/2017 at 2:58 p.m., the director of nursing (DON) stated the Restorative Care Program was part of R5's comprehensive care plan, and it was nursing's responsibility to make sure the program was followed. The DON acknowledged R5's restorative program was not consistently completed for several months, and also lacked documentation that R5's program was completed at all since mid-November. The DON stated it was difficult to find staff to do the programs, especially at the end of the year, and the restorative nursing program struggled. The	F 318		

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F 318	Continued From page 30 DON stated she "absolutely" expected R5's, and other residents' care plans be followed, and the restorative nursing programs be implemented. R15's quarterly MDS, dated 10/19/16, identified no cognitive impairment and needed extensive assistance with mobility and transfers, and had a functional limitation of the lower extremity on one side. R15's ROM/Balance Assessment, dated 7/22/16, identified a left lower extremity impairment related to a previous left hip fracture. The assessment indicated the impairment affected R15's physical functioning, and R15 did not utilize any braces or splints. It further indicated physical therapy ended on 7/21/16, as R15 refused to participate. R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated the "left leg continues to be stiff and slower with movement," and R15 was not able to completely flex or extend the leg. It indicated R15 was on a Nursing Rehab program for exercises. R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as tolerated or would agree to. R15's restorative program included using the NuStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.	F 318		

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R15's current care plan, dated 10/25/16, identified R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions, but there was no indication R15 was on a restorative program or that he refused restorative exercises.

Review of R15's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R15 had ROM completed seven times, with a, "X" (meaning no staff were available for exercise) being written in six times on the remaining days. R15 was identified as refusing once.

October 2016: R15 had ROM completed nine times, with a, "X" being written in 17 times on the remaining days. R15 was identified as refusing the ROM four times.

November 2016: R15 had ROM completed five times, with a, "X" being written in nine times with the remainder of the form (after 11/16/16) being left blank. R15 was identified as refusing the ROM twice.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

During interview on 1/4/17, at 6:02 p.m. R15 stated he did exercises "when I'm ready," further stating the times he went to exercise varied.

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During observation of morning cares on 1/5/16, at 7:11 a.m. registered nurse (RN)-B and nursing assistant (NA)-F were observed assisting R15 to the bathroom. With assistance and a transfer belt, R15 was able to stand from his wheelchair, ambulated a few step, and sit down on the toilet. NA-F proceeded to provide R15 with washcloths. R15 was observed to independently wash his face and upper body. NA-F assisted R15 to dress his upper body, R15 was able to use his upper extremities to assist with dressing. NA-F proceeded to put on R15's pants on while he sat on the toilet. After completing morning cares, NA-F placed the wheelchair in the bathroom next to the toilet and, with assistance, R15 grabbed the assistance bar, stood while NA-F pulled up the pants, and sat down in the wheelchair. No restorative exercises were performed during the observation.

During interview on 1/5/17, at 7:34 a.m. NA-F stated it was the first time she had worked with R15 and wasn't aware of any restorative program.

During interview on 1/5/17, at 7:49 a.m. NA-C stated R15 worked with the physical therapist sometimes; however, wasn't sure if R15 was on a restorative program. NA-C stated the restorative programs used to be completed by a few nursing assistants, but hadn't "seen that in a while."

During interview on 1/5/17, at 11:42 a.m. NA-B stated R15 had a restorative program; however, the nursing assistants hadn't had time to complete it for the last couple of months due to staffing. NA-B further stated R15 was "pretty consistent" with doing the restorative exercises. She further stated he came to the restorative

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program more than he refused, disliked the NuStep, and would occasionally use ankle weights and do stretches.

During interview on 1/5/17, at 11:58 a.m. RN-A stated the facility had two nursing assistants, trained by the the physical therapist, who performed the restorative program. RN-A further states the restorative program wasn't being done "pretty often," depending on the week, because the nursing assistants were not consistently working as restorative aides.

During interview on 1/5/17, at 12:22 p.m. physical therapist (PT)-A stated R15 had worked with her on the NuStep and with doing a few exercises for his legs. PT-A stated R15 had been more combative with therapy when he was first admitted to the facility, but thought he was being offered restorative exercises and was currently refusing less to perform exercises. In addition, PT-A states "he sporadically wheels himself down (to the exercise room)" to do restorative nursing.

During observation on 1/5/17, at 4:01 p.m. PT-A was observed performing ROM on R15. PT-A reported R15 had no decline in his ROM and had no contractures. PT-A reported the goal of R15's restorative program was to prevent contractures after his previous left hip fracture.

R29's quarterly MDS dated 11/11/16, identified R29 had severe cognitive impairment, was totally dependent on staff for her ADLs, and had impaired functional range of motion (ROM) on both of her upper extremities.

R29's Restorative Care Program dated 5/18/15,

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identified a goal to, "Maintain ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated by resident," with a frequency of "7x/wk."

R29's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R29 had ROM completed eight times, with a, "X" being written in 22 times on the remaining days.

October 2016: R29 had ROM completed 12 times, with a, "X" being written in 19 times on the remaining days.

November 2016: R29 had ROM completed five times, with a, "X" being written in 11 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

R12's quarterly MDS dated 9/14/16, identified R12 had moderate cognitive impairment, required extensive assistance with ADLs, and had impaired functional ROM on both of his upper and lower extremities.

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F 318	Continued From page 35 R12's Restorative Care Program dated 12/16/16, identified a diagnosis of, "Joint limitation of movement," and listed a goal to, "Maintain R U/E [right upper extremity] function for self feeding." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "AAROM [active assisted range of motion] R [right] shoulder," and listed several instructions for staff to follow using weights with R12's flexion and extension exercises. Further, the program identified the restorative program should be completed 4 times a week. R12's Nursing Rehab forms were requested, however there were no flowsheets to demonstrate the restorative program had been attempted or completed sine being implemented on 12/16/16. During interview on 1/5/17, at 2:09 p.m. RN-A stated the resident restorative programs had not been completed for what, "Seems like awhile," due to not having enough staff, "The staffing's been difficult with that." Further, RN-A stated residents should have had their restorative programs completed as directed to, "Prevent further loss," of their mobility. A facility policy on restorative nursing program implementation was requested, but none was provided.	F 318		
F 465 SS=D	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON (h) Other Environmental Conditions	F 465		1/13/17

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F 465	Continued From page 36 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a clean and sanitary environment in 2 of 8 resident rooms (A8 and A10), reviewed on the A wing, which had the potential to affect 2 residents who currently utilized these rooms. Findings include: During observation of resident rooms on 1/5/17, at 8:44 a.m. the privacy curtain in room A10 was observed stained and unclean. The staining, from an unknown substance, appeared as dark, brown-colored dots and inch-long marks, on the lower portion of the curtain, which was hanging close to the room door. The curtain in Room A8 was also inspected and observed unclean, with a brownish-colored and faded stain, also on the lower portion of the gathered curtain, near the door. During an environmental tour on 1/5/17, at 1:40 p.m. with the maintenance supervisor (MS) and in the presence of the surveyor, the curtains in room A10 and A8 were reviewed. The MS acknowledged both curtains were unclean and in need of changing and cleaning.	F 465	Privacy curtains for both rooms A10 and A 8 were replaced with clean curtains. All other privacy curtains were examined and replaced as needed. Privacy curtain examination and replacement will be added to monthly environmental inspection forms to ensure specific and adequate attention to curtain cleanliness. Maintenance inspection results and trends will be reviewed with the QAU committee to adjust frequency and compliance. Overall Responsibility: Maintenance Supervisor	

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F 465	Continued From page 37 In an interview on 1/5/17, at 1:43 p.m. the MS stated the curtains were dirty, that one of the residents used the privacy curtain "like a Kleenex," wipe her mouth and added the stain could be vomit. The MS stated rooms were painted, repaired and cleaned top to bottom when a resident moved out, but that on a monthly basis there also was a more detailed checklist used to clean and repair resident rooms. The MS stated when housekeeping goes through the room every day, if they notice an issue, like a dirty curtain, they would fill out a request , and then the MS would go in remove and replace the curtain, and the dirty one would be washed. The MS stated the curtain should have been changed sooner, and stated he could just make is a task to "change out" the curtains on a monthly basis. A facility document, Central Todd County Care Center (CTCCC) Room Inspection List, was reviewed, and indicated privacy curtains were to be checked monthly. A policy regarding the cleaning and maintaining of resident rooms was requested, but not provided during the survey.	F 465		
F 520 SS=E	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services;	F 520		2/3/17

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F 520	Continued From page 38 (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee developed and implemented a plan of action to address the lack of restorative nursing programs being consistently implemented for 5 of 5 residents (R35, R5, R15, R29, and R12) reviewed for range	F 520	Action plan for rehab nursing program evaluation, organization and execution was presented to QAU team to review citations, and suggest plan of correction. QAU approved action plan. QAU will review weekly audits of rehab nursing program documentation over the next two	

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F 520	Continued From page 39 of motion services. This had the potential to affect all 30 residents identified by the facility receiving restorative programs. Findings include: R35's significant change MDS dated 11/16/16, identified R35 had severe cognitive impairment, was totally dependent on staff for her activities of daily living (ADLs), and had impaired functional range of motion (ROM) on both of her upper and lower extremities. R35's care plan dated 11/22/16, identified R35 had an alteration in ADLs and had, "Dependence on staff." Further, the care plan identified several interventions including, "Restorative Program." The Restorative Care Program dated 7/1/15, identified R35 was to receive, "ROM to all extremities daily as tolerated," with a frequency of seven times a week. R35's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet to record exercise completed on each day. From September to November 2016 R35 received ROM 19 times for three months. There were no restorative forms for December 2016 or January 2017. R5's significant change Minimum Data Set (MDS) dated 10/13/16, included pain in left hip, and indicated R5 required extensive assistance for bed mobility, transferring and dressing, and was cognitively impaired. R5's care plan, revised 10/7/2016, identified an ADL self-care deficit, related to pain, history of left	F 520	quality assurance meetings to ensure compliance and integrity of the program and recommend changes if needed. QAU team were educated on the citation and QAU roles and expectations with regard to staff prioritization and programming oversight. Overall responsibility: Director of Nursing	

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	245521	A. BUILDING ______ B. WING ______	01/05/2017

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F 520	Continued From page 40	F 520		

hip fracture, and included the intervention of a restorative program.

R5's "Restorative Care Program," revised 11/16/15, identified specific upper and lower extremities exercise for R5 for strengthening.

R5's Nursing Rehab sheets from July 2016 to November 2016 identified R5 only completed the exercise program on 22 days during the past three months. There was no documentation for December 2016 or January 2017.

R15's quarterly MDS, dated 10/19/16, identified no cognitive impairment and needed extensive assistance with mobility and transfers, and had a functional limitation of the lower extremity on one side.

R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transferring, maintain left lower extremity strength, and to encourage ambulation as tolerated. R15's restorative program included using the NuStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.

Review of R15's Nursing Rehab forms dated 9/2016 to 11/2016, identified he completed his exercise 21 times in the past three months. There was no documentation for December 2016 and January 2017 for R15 ' s rehab nursing.

R29's quarterly MDS dated 11/11/16, identified R29 had severe cognitive impairment, was totally dependent on staff for her ADLs, and had

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F 520	Continued From page 41	F 520		

impaired functional range of motion (ROM) on both of her upper extremities.

R29's Restorative Care Program dated 5/18/15, ROM to all extremities daily as tolerated by resident, seven days a week.

Review of R29's Nursing Rehab forms dated 9/2016 to 11/2016, identified exercises were completed 25 times in the past three months. There was no documentation for December 2016 and January 2017 for R29 ' s rehab nursing.

R12's quarterly MDS dated 9/14/16, identified R12 had moderate cognitive impairment, required extensive assistance with ADLs, and had impaired functional ROM on both of his upper and lower extremities.

R12's Restorative Care Program dated 12/16/16, AAROM (active assisted range of motion) to right shoulder using weights for flexion and extension exercises, four time a week.
R12's Nursing Rehab forms were requested, however there were no flowsheets to demonstrate the restorative program had been attempted or completed since being implemented on 12/16/16.

During interview on 1/5/17, at 7:34 a.m. NA-F stated she was not aware of any restorative program.

During interview on 1/5/17, at 7:49 a.m. NA-C stated the restorative programs used to be completed by a few nursing assistants, but hadn't "seen that in a while."

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F 520	Continued From page 42	F 520		

During interview on 1/5/17, at 7:56 a.m. NA-A stated the facility had a couple other NA staff responsible to complete the restorative programs, however, when the facility is short staffed, those aides are pulled to the floor, "We don't do rehab when we are short on the floor."
During an interview on 1/5/2017, at 2:06 p.m. nursing assistant (NA)-B stated she was one of the rehab aides, and she "dutifully" completed restorative nursing programs with residents. NA-B stated that about November, there were no staff available to complete the programs, and she was often "pulled" from rehab assignments to work on the floor, as often as five times a week.

Review of the facility Restorative Program Central Todd County Care Center (CTCCC) Resident List dated 1/2017, identified 30 residents were currently on active restorative nursing programs in the facility.

On 1/5/17, at 2:09 p.m. registered nurse (RN)-A was interviewed regarding the restorative nursing programs not being completed in the facility. RN-A stated the administration was aware the programs were not being completed adding, "They know it hasn't been done." Further, RN-A stated she was unaware if this concern had ever been brought to the facility QA committee to be addressed.

The facility Quality Assurance Signature Form(s) were reviewed and identified the most recent QA meetings were held on 11/18/16, and 8/26/16.

During interview on 1/5/17, at 4:07 p.m. the director of nursing (DON) stated she was aware restorative nursing was not being completed per the restorative plans of care. DON also stated

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F 520	Continued From page 43	F 520		

restorative nursing not getting completed was brought to her attention based on the facility staffing shortage. She further stated she was aware when the facility had only one or two rehab aides working, the aides often got pulled from completing restorative nursing to work as aides on the floor. DON stated she had known getting restorative nursing completed as planned had been an issue for a few months, but this had never been discussed in the QA&A meetings. Further, DON stated the QA&A committee had discussed staffing concerns, but no discussion had taken place in regards to restorative nursing not getting completed, or what to do about this concern. DON added, moving forward, restorative nursing would be reviewed at QA&A and a plan of action would be implemented.

During interview on 1/5/17, at 4:19 p.m. the administrator stated he was aware of staffing shortages at the facility that prevented restorative nursing from getting completed. He stated two staff were designated as rehab staff and that is what he had budgeted for and planned for, but when the facility was short staffed, the rehab aides got pulled to work the floor. The administrator added, we have discussed staffing concerns at QA&A, but not specifically the resident rehabilitation program.

A facility Quality Assurance Plan policy, revised 4/2015, identified several goals of the QA&A committee including, "Improves or maintains resident outcomes according to standards imposed or determined," and, "Improves processes within the organization to promote satisfactory outcomes for residents, improves efficiency and maintains adequate cost control," and, "Assessing and defining needs and

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F 520	Continued From page 44 problems of residents and staff for improving some aspect/s or resident care and/or facility operations."	F 520		

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

F5521025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**01/05/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Central Todd County Care Center 01 Main Building was found 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. Central Todd County Care Center is a 1-story building without a basement. The building was constructed at 4 different times. The original building was constructed in 1976 and was determined to be of Type V(111) construction. In 1985, an addition was added to the service wing on the south side and was determined to be of Type V(111). In 1992 an activities/ physical therapy addition was added to the east end of A Wing and was determined to be of Type V(111) construction. In 2002 additions were added to west end of D Wing, to the main entrance and between E and D wings dining room, all of which are Type V(111) construction. An assisted living apartment building is attached to the B wing which is separated by a 2-hour fire barrier. The north end of E wing are apartments and separated from the nursing home with a 2-hour fire barrier. The building is divided into 4 smoke zones by 2 hour fire barriers. The building is protected by a complete automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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

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.

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

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	245521	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**01/05/2017**

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K 000	Continued From page 1 The facility has a capacity of 60 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically submitted
January 20, 2017

Mr. Jason Polovick, Administrator
Central Todd County Care Center
406 East Highway 71, Po Box 38
Clarissa, MN 56440

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5521026

Dear Mr. Polovick:

The above facility was surveyed on January 3, 2017 through January 5, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was found to be unsubstantiated. 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 deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 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. 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.

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. 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 Brenda Fischer at: (320) 223-7338 or email: brenda.fischer@state.mn.us**.

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 eNotice.

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
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00761	A. BUILDING: ______ B. WING ______	01/05/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER 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. 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. 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. INITIAL COMMENTS: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On January 3-5, 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. 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 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. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Quality Assessment and Assurance (QA&A) committee developed and implemented a plan of action to address the lack of restorative nursing programs being consistently implemented for 5 of 5 residents (R35, R5, R15, R29, and R12) reviewed for range of motion services. This had the potential to affect all 30 residents identified by the facility receiving restorative programs. Findings include:	2 255	Corrected.	1/27/17

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2 255	Continued From page 3 R35's significant change MDS dated 11/16/16, identified R35 had severe cognitive impairment, was totally dependent on staff for her activities of daily living (ADLs), and had impaired functional range of motion (ROM) on both of her upper and lower extremities. R35's care plan dated 11/22/16, identified R35 had an alteration in ADLs and had, "Dependence on staff." Further, the care plan identified several interventions including, "Restorative Program." The Restorative Care Program dated 7/1/15, identified R35 was to receive, "ROM to all extremities daily as tolerated," with a frequency of seven times a week. R35's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet to record exercise completed on each day. From September to November 2016 R35 received ROM 19 times for three months. There were no restorative forms for December 2016 or January 2017. R5's significant change Minimum Data Set (MDS) dated 10/13/16, included pain in left hip, and indicated R5 required extensive assistance for bed mobility, transferring and dressing, and was cognitively impaired. R5's care plan, revised 10/7/2016, identified an ADL self-care deficit, related to pain, history of left hip fracture, and included the intervention of a restorative program. R5's "Restorative Care Program," revised 11/16/15, identified specific upper and lower extremities exercise for R5 for strengthening.	2 255		

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2 255	Continued From page 4	2 255		

R5's Nursing Rehab sheets from July 2016 to November 2016 identified R5 only completed the exercise program on 22 days during the past three months. There was no documentation for December 2016 or January 2017.

R15's quarterly MDS, dated 10/19/16, identified no cognitive impairment and needed extensive assistance with mobility and transfers, and had a functional limitation of the lower extremity on one side.

R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transferring, maintain left lower extremity strength, and to encourage ambulation as tolerated. R15's restorative program included using the NuStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.

Review of R15's Nursing Rehab forms dated 9/2016 to 11/2016, identified he completed his exercise 21 times in the past three months. There was no documentation for December 2016 and January 2017 for R15 ' s rehab nursing.

R29's quarterly MDS dated 11/11/16, identified R29 had severe cognitive impairment, was totally dependent on staff for her ADLs, and had impaired functional range of motion (ROM) on both of her upper extremities.

R29's Restorative Care Program dated 5/18/15, ROM to all extremities daily as tolerated by resident, seven days a week.

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2 255	Continued From page 5 Review of R29's Nursing Rehab forms dated 9/2016 to 11/2016, identified exercises were completed 25 times in the past three months. There was no documentation for December 2016 and January 2017 for R29 ' s rehab nursing. R12's quarterly MDS dated 9/14/16, identified R12 had moderate cognitive impairment, required extensive assistance with ADLs, and had impaired functional ROM on both of his upper and lower extremities. R12's Restorative Care Program dated 12/16/16, AAROM (active assisted range of motion) to right shoulder using weights for flexion and extension exercises, four time a week. R12's Nursing Rehab forms were requested, however there were no flowsheets to demonstrate the restorative program had been attempted or completed since being implemented on 12/16/16. During interview on 1/5/17, at 7:34 a.m. NA-F stated she was not aware of any restorative program. During interview on 1/5/17, at 7:49 a.m. NA-C stated the restorative programs used to be completed by a few nursing assistants, but hadn't "seen that in a while." During interview on 1/5/17, at 7:56 a.m. NA-A stated the facility had a couple other NA staff responsible to complete the restorative programs, however, when the facility is short staffed, those aides are pulled to the floor, "We don't do rehab when we are short on the floor." During an interview on 1/5/2017, at 2:06 p.m. nursing assistant (NA)-B stated she was one of	2 255		

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2 255	Continued From page 6	2 255		

the rehab aides, and she "dutifully" completed restorative nursing programs with residents. NA-B stated that about November, there were no staff available to complete the programs, and she was often "pulled" from rehab assignments to work on the floor, as often as five times a week.

Review of the facility Restorative Program Central Todd County Care Center (CTCCC) Resident List dated 1/2017, identified 30 residents were currently on active restorative nursing programs in the facility.

On 1/5/17, at 2:09 p.m. registered nurse (RN)-A was interviewed regarding the restorative nursing programs not being completed in the facility. RN-A stated the administration was aware the programs were not being completed adding, "They know it hasn't been done." Further, RN-A stated she was unaware if this concern had ever been brought to the facility QA committee to be addressed.

The facility Quality Assurance Signature Form(s) were reviewed and identified the most recent QA meetings were held on 11/18/16, and 8/26/16.

During interview on 1/5/17, at 4:07 p.m. the director of nursing (DON) stated she was aware restorative nursing was not being completed per the restorative plans of care. DON also stated restorative nursing not getting completed was brought to her attention based on the facility staffing shortage. She further stated she was aware when the facility had only one or two rehab aides working, the aides often got pulled from completing restorative nursing to work as aides on the floor. DON stated she had known getting restorative nursing completed as planned had been an issue for a few months, but this had

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never been discussed in the QA&A meetings. Further, DON stated the QA&A committee had discussed staffing concerns, but no discussion had taken place in regards to restorative nursing not getting completed, or what to do about this concern. DON added, moving forward, restorative nursing would be reviewed at QA&A and a plan of action would be implemented.

During interview on 1/5/17, at 4:19 p.m. the administrator stated he was aware of staffing shortages at the facility that prevented restorative nursing from getting completed. He stated two staff were designated as rehab staff and that is what he had budgeted for and planned for, but when the facility was short staffed, the rehab aides got pulled to work the floor. The administrator added, we have discussed staffing concerns at QA&A, but not specifically the resident rehabilitation program.

A facility Quality Assurance Plan policy, revised 4/2015, identified several goals of the QA&A committee including, "Improves or maintains resident outcomes according to standards imposed or determined," and, "Improves processes within the organization to promote satisfactory outcomes for residents, improves efficiency and maintains adequate cost control," and, "Assessing and defining needs and problems of residents and staff for improving some aspect/s or resident care and/or facility operations."

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could review and revise policies related to the appropriate functions of the QA committee related to identified concerns and the development and implementation of an action plan. The

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2 255	Continued From page 8 administrator of designee could develop an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 255		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents 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). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan which included specific interventions for resident behaviors/mood status for 2 of 2 residents (R15, R48) reviewed who were on an antidepressant. Further, the facility failed to develop and identify a restorative program on the care plan for 1 of 5 residents (R15) who received range of motion (ROM) in the facility. Findings include: ANTIDEPRESSANT MEDICATION R15's 30 day scheduled Minimum Data Set (MDS), dated 9/12/16 identified R15 had moderate cognitive impairment. R15's current	2 560	Corrected.	1/6/17

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diagnosis list identified a new diagnosis of "major depressive disorder, single episode, unspecified," dated 9/13/16.

R15's PHQ-9 (a tool used to evaluate depression symptoms), dated 9/12/16, identified R15 had experienced little interest or pleasure in doing things, felt down, depressed, or hopeless and experienced feeling tired or having little energy, "12-14 days" during the two week period.

R15's current physician orders, dated 12/7/16, identified R15 had active orders for, Cymbalta (an antidepressant medication) 60 mg (milligrams) once a day for depression which was started on 9/13/16.

R15's care plan, dated 10/25/16, identified R15 had impaired cognition with varying confusion, forgetfulness and dementia. The care plan did not identify R15 had a depressed mood, hopelessness, little energy or used an antidepressant. There were no specific interventions identified for staff to implement to help decrease or elevate R15's depressed mood and hopelessness.

During interview on 1/5/17, at 7:49 a.m. nursing assistant (NA)-C stated R15 used to have depressed mood, but further states she thought "it has gotten better."

During interview on 1/5/17, at 11:58 a.m. registered nurse (RN)-A stated the physician's dictation from 9/13/16 indicated an order for Cymbalta for moderate depression and left leg pain. RN-A further stated R15 had "seemed down." RN-A reported R15's care plan should contain a mood focus, address the Cymbalta, and contain interventions for depression symptoms,

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2 560	Continued From page 10 which was missing. During interview on 1/5/17, at 3:11 p.m. the director of nursing (DON) stated a mood focus along with behaviors were expected to be on the care plan. R48's quarterly MDS dated 12/1/16, identified R48 had severe cognitive impairment and depression. R48's physician orders dated 1/5/17, identified R48 had active orders for, Celexa (antidepressant medication) 10 mg by mouth one time a day for major depressive disorder, single episode, with a start date of 9/27/16. R48's PHQ-9 (a tool used to evaluate depression symptoms) dated 12/1/16, identified R48 experienced feeling tired and having little energy, "12-14 days" during a two week period. Further, R48 was identified as having, "Minor Depressive Syndrome," on the assessment. R48's Psychiatric Progress Note dated 12/21/16, identified R48 was followed to, "...establish psychiatric care and manage psychotropic's [medications]." The note identified R48 had her Celexa reduced and was, "more animated and she is more social with other residents." Further, the note included a treatment plan which include, "Staff to continue to use psychosocial, interpersonal and environmental interventions to manage behaviors." R48's care plan dated 12/6/16, identified R48 had impaired cognition with short and long term memory loss, however lacked any information	2 560		

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about R48's feeling tired, having little energy or the use of an antidepressant medication. There were no specific interventions identified for staff to implement to help reduce or elevate R48's identified symptoms of depression.

During interview on 1/5/17, at 1:41 p.m. NA-A stated R48 was typically a, "Sweet lady," however, at times would become depressed and weepy. NA-A stated she was unaware of any specific interventions to help R48 when she is depressed besides just providing reassurance or offering to take her to activities.

When interviewed on 1/5/17, at 2:16 p.m. registered nurse (RN)-A stated R48 had been, pretty withdrawn for awhile, but was doing better while taking the ordered Celexa. RN-A reviewed R48's care plan and stated her use of antidepressant medication or any specific interventions to help her depression were not identified. There should be a mood focus and there is not. Further, RN-A stated R48's history of depression and use of psychotropic medications should be identified on her care plan.

RESTORATIVE PROGRAM:

R15's quarterly MDS, dated 10/19/16, identified no cognitive impairment and needed extensive assistance with mobility and transfers, and had a functional limitation of the lower extremity on one side.

R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as he tolerated or would agree to. R15's restorative

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2 560	Continued From page 12 program included using the NuStep (exercise bike), and performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions. R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated the "left leg continues to be stiff and slower with movement." R15 was not able to completely flex or extend the leg but was on a Nursing Rehab program for exercises. R15's current care plan, dated 10/25/16, identified R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions; however, it did not identify R15 was on a restorative program or at times he refused restorative exercises, even though the restorative plan had been in place since 9/17/16. During interview on 1/5/17, at 1:13 p.m. RN-C stated care plans were updated on admission and quarterly with assessments; however, since R15's restorative program was started in between his admission and quarterly assessments, the care plan had not been updated. RN-C stated it "was an error." RN-C further reported R15's care plan did not identify he refused the restorative program at times, and should be identified. A facility Resident Assessment and Interdisciplinary Care Planning policy dated 11/2016, identified a comprehensive assessment should be completed and , "All problems and potential problems identified in this assessment are documented by entering a focus statement on	2 560		

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2 560	Continued From page 13 the Care Plan." Further, the policy directed each identified problem should, " ... be incorporated into the Care Plan which identifies goals, approaches, target dates of completion, and assigned responsibilities." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure restorative programs were implemented as directed by the care plan for 4 of 5 residents (R5, R35, R29, and R12) reviewed for range of motion services. Findings include: R5's diagnoses, as identified on the significant change Minimum Data Set (MDS) dated	2 565	Corrected.	1/6/17

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10/13/16, included pain in left hip, anemia and Alzheimer's dementia. The MDS also indicated R5 required extensive assistance for bed mobility, transferring and dressing, and was cognitively impaired.

R5's care plan, revised 10/7/2016, identified an activity of daily level (ADL) self-care deficit, related to pain, history of left hip fracture, and included the intervention of a restorative program. R5's Restorative Care Program, included the following directions: 10 times 1-2 pound free weights on bilateral, upper extremities, flex and extend elbow, punch out and internal rotation; sit and use upper extremity bike 5 minutes, with rest as needed; overhead pulley with no weight 3 to 4 minutes; daily walk 60 feet; and NuStep (seated, exercise machine) level one for 10 minutes.

During observation on 1/5/2017, at 7:13 a.m. nursing assistant (NA)-D provided R5 with morning cares, and also assisted R5 to transfer from the bed into her wheelchair. There was no restorative services provided during the provision of morning cares for R5.

In an interview on 1/5/17, at 7:50 a.m. NA-D stated she did not today, nor routinely, work on restorative programs, but was sure R5 had one. NA-D stated there were other aides who did the rehab programs.

Review of the Facility Nursing Rehab sheets from July 2016 to November 2016 were reviewed. The documentation indicated R5's restorative services were provided/refused or unavailable as follows: July, 5x (times), 1x refused; August, 3x, 1x refused, 2 x unavailable; September, 5x, 1x refused; October, 6x, 4x refused; November 3x, 2x refusals, 1x unavailable; there was no

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documentation after November 15th; December: no documentation; and January 2017: no documentation.

During an interview on 1/5/2017, at 2:06 p.m. nursing assistant (NA)-B stated she was one of the rehab aides, and she "dutifully" completed restorative nursing programs with residents. NA-B stated that about November, however, there were no staff available to complete the programs, and she was often "pulled" from rehab assignments to work on the floor, as often as five times a week. NA-B stated R5's restorative goal was five times a week, but "it just didn't get done." NA-B stated it was no surprise there was little or no documentation of the rehab program for R5 since the middle of November.

In an interview on 1/5/17, at 2:58 p.m. the director of nursing (DON) stated the Restorative Care Program was part of R5's comprehensive care plan, and it was nursing's responsibility to make sure the program was followed. The DON acknowledged R5's restorative program was not consistently completed for several months, and also lacked documentation that R5's program was completed at all since mid-November. The DON stated she "absolutely" expected R5's, and other residents' care plans be followed, and the restorative nursing programs be completed.

R35's significant change MDS dated 11/16/16, identified R35 had severe cognitive impairment, was totally dependent on staff for her activities of daily living (ADLs), and had impaired functional range of motion (ROM) on both of her upper and lower extremities.

R35's care plan dated 11/22/16, identified R35

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had an alteration in ADLs and had, "Dependence on staff." Further, the care plan identified several interventions including, "Restorative Program."

R35's Restorative Care Program dated 7/1/15, identified R35 had right sided upper and lower extremity weakness due to a stroke, and listed a goal of her program as, "Maintain current ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated," with a frequency of "7x/wk [times per week]."

During observation of morning care on 1/5/17, at 7:47 a.m. nursing assistant (NA)-A and NA-B assisted her with rising and seated her in her wheelchair. No ROM was completed on R35's upper or lower extremities during the morning care.

During interview on 1/5/17, at 8:45 a.m. NA-B stated stated R35 was supposed to have ROM completed daily, however, it was not being done, "Due to not having full staff." NA-B stated R35 had not had ROM completed as directed by her program for over a month, and R35's contractures were, "progressively getting worse," and R35 seemed, "Tighter," when staff completed cares. NA-B stated the staff tracked participation with the ROM programs on a flowsheet by signing their initials when it was done, or a, "X" symbol when it was not completed.

R35's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which

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identified the following entries:

September 2016: R35 had ROM completed four times, with a, "X" being written in 26 times on the remaining days.

October 2016: R35 had ROM completed seven times, with a, "X" being written in 23 times on the remaining days. R35 was identified as refusing the ROM once.

November 2016: R35 had ROM completed four times, with a, "X" being written in 12 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

When interviewed on 1/5/17, at 9:20 a.m. registered nurse (RN)-B stated R35 was on a restorative nursing program for her arm contractures and should have ROM completed to her arms daily, "To maintain their current range of motion and prevent further contractures."

R29's quarterly MDS dated 11/11/16, identified R29 had severe cognitive impairment, was totally dependent on staff for her ADLs, and had impaired functional range of motion (ROM) on both of her upper extremities.

R29's care plan dated 11/21/16, identified R29 had self care performance deficit with a left hand contracture. The care plan directed staff with interventions including, "Restorative Rehab Program."

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R29's Restorative Care Program dated 5/18/15, identified a goal to, "Maintain ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated by resident," with a frequency of "7x/wk."

R29's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R29 had ROM completed eight times, with a, "X" being written in 22 times on the remaining days.

October 2016: R29 had ROM completed 12 times, with a, "X" being written in 19 times on the remaining days.

November 2016: R29 had ROM completed five times, with a, "X" being written in 11 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

R12's quarterly MDS dated 9/14/16, identified R12 had moderate cognitive impairment, required extensive assistance with ADLs, and had impaired functional ROM on both of his upper and

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lower extremities.

R12's care plan dated 12/19/16, identified R12 was at risk for falls related to impaired mobility and balance, and directed staff to complete a, "Restorative Program."

R12's Restorative Care Program dated 12/16/16, identified a diagnosis of, Joint limitation of movement, and listed a goal to, Maintain R U/E [right upper extremity] function for self feeding. The sheet provided a space labeled, Approaches/Recommendations for Implementation of Above Goals, and directed staff to complete, "AAROM [active assisted range of motion] R [right] shoulder," and listed several instructions for staff to follow using weights with R12's flexion and extension exercises. Further, the program identified the restorative program should be completed 4 times a week.

R12's Nursing Rehab forms were requested, however none were provided to demonstrate the restorative program had been attempted or completed since being implemented on 12/16/16.

During interview on 1/5/17, at 2:09 p.m. RN-A stated a care plan was used to ensure residents are, "Getting their needs met," and staff were expected to implement them or update the nurses so interventions could be revised and addressed. Further, RN-A stated residents should have had their restorative programs completed as directed to, "Prevent further loss," of their mobility.

A facility Resident Assessment and Interdisciplinary Care Planning policy dated 11/2016, identified a comprehensive assessment should be completed and , "All problems and potential problems identified in this assessment

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2 565	Continued From page 20 are documented by entering a focus statement on the Care Plan." Further, the policy directed each identified problem should, " ... be incorporated into the Care Plan which identifies goals, approaches, target dates of completion, and assigned responsibilities." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative nursing programs to ensure functional range of	2 895	Corrected.	1/9/17

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motion was maintained for 5 of 5 residents (R35, R5, R15, R29, and R12) reviewed for range of motion services.

Findings include:

R35's significant change MDS dated 11/16/16, identified R35 had severe cognitive impairment, was totally dependent on staff for her activities of daily living (ADLs), and had impaired functional range of motion (ROM) on both of her upper and lower extremities.

R35's care plan dated 11/22/16, identified R35 had an alteration in ADLs and had, "Dependence on staff." Further, the care plan identified several interventions including, "Restorative Program."

R35's Restorative Care Program dated 7/1/15, identified R35 had right sided upper and lower extremity weakness due to a stroke, and listed a goal of her program as, "Maintain current ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated," with a frequency of "7x/wk [times per week]." Further, the program identified R35 had been discharged from hospice care on 11/14/16.

During observation on 1/4/17, at 12:32 p.m. R35 was seated in a high-back reclining wheelchair in her room listening to the radio with her eyes closed. R35 had visible contractures of her shoulders, elbows and hands as she held her arms toward her upper chest. R35 had no visible splints or braces in place on her arms or hands.

During interview on 1/4/17, at 1:34 p.m. registered nurse (RN)-A stated R35 was, "kinda

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bent in the arms," and had contractures in her upper and lower extremities due to a stroke suffered years prior. Further, RN-A stated R35 did not use braces or splints, but received daily range of motion to help with her contractures.

During observation of morning care on 1/5/17, at 7:47 a.m. nursing assistant (NA)-A and NA-B assisted her with rising and seated her in her wheelchair. No ROM was completed on R35's upper or lower extremities during the morning care.

When interviewed on 1/5/17, at 7:56 a.m. NA-A stated she typically helps R35 get ready a, "Couple times a week," and does not ever complete ROM or exercises with R35. NA-A stated she was not aware if R35 was on a restorative nursing program, but added, "She's very stiff," when staff are helping her dress. Further, NA-A stated the facility had a couple other NA staff responsible to complete the restorative programs, however, when the facility is short staffed, those aides are pulled to the floor, "We don't do rehab when we are short on the floor."

During interview on 1/5/17, at 8:45 a.m. NA-B stated she was one of two NA staff responsible to complete the restorative programs for residents. NA-B stated R35 was supposed to have ROM completed daily, however, it was not being done, "Due to not having full staff." NA-B stated R35 had not had ROM completed as directed by her program for over a month, and R35's seemed, "Tighter," when staff completed cares. NA-B stated the staff tracked participation with the ROM programs on a flowsheet by signing their initials when it was done, or a, "X" symbol when it was not completed. Further, NA-B stated she

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had reported these concerns to the occupational therapist (OT).

R35's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R35 had ROM completed four times, with a, "X" being written in 26 times on the remaining days.

October 2016: R35 had ROM completed seven times, with a, "X" being written in 23 times on the remaining days. R35 was identified as refusing the ROM once.

November 2016: R35 had ROM completed four times, with a, "X" being written in 12 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

When interviewed on 1/5/17, at 9:20 a.m. registered nurse (RN)-B stated R35 was on a restorative nursing program for her arm contractures and should have ROM completed to her arms daily, "To maintain their current range of motion and prevent further contractures." RN-B stated the restorative NA staff were responsible to complete the cares of each program, however, they were being pulled to the floor to work instead, "Two or three times a week, if not more."

During interview on 1/5/17, at 1:09 p.m. OT-A

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stated it had been a few years, since R35 had been last seen by OT for any therapy services, however, added she had recently requested orders for R35 to be evaluated due to nursing staff reported R35 to have, "Some tightness in her elbows and wrists."

On 1/5/17, at 1:12 p.m. OT-A completed passive range of motion (PROM) to R35's upper extremities with the surveyor present. OT-A stated R35 had poor abduction (motion of the joint away from the body) in her left shoulder adding it was, "Very, very tight." OT-A stated R35 was, "Probably missing 35 to 45 degrees of extension," in her left elbow. Further, OT-A completed PROM to R35's right side and stated R35's right shoulder was better than her left side with, "About 20 degrees of abduction," and, "20 degrees of flexion [the action of bending]," however, added R35's right elbow was, "Minus 25 or 30 degrees."

When interviewed following the PROM on 1/5/17, at 1:25 p.m. OT-A stated she had not personally worked with R35 prior, so she was unable to determine if a decline in R35's ROM had occurred or not. Further, OT-A stated nursing staff should be completing the ROM exercises to help increase the circulation and potentially reduce R35's pain with dressing and other activities of daily living, "That is something that would be good to educate nursing staff on."

R5's diagnoses, as identified on the significant change Minimum Data Set (MDS) dated 10/13/16, included pain in left hip, anemia and Alzheimer's dementia. The MDS also indicated R5 required extensive assistance for bed mobility, transferring and dressing, and was cognitively impaired.

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A Range of Motion (ROM)/Balance Assessment, dated 12/28/2016, indicated R5 had difficulty touching behind her head, was able to reach to about shoulder height; was able to flex and extend right leg and foot and left hand. The assessment also indicated R5 had difficulty extending left leg, had pain and stiffness to leg, and that impairments to upper and lower left extremity affected R5's daily physical functioning. Further, R5 was able to stand from seated position with use of a grab bar, and completed surface to surface transfer independently. R5 received increased assistance from staff depending on pain and weakness.

R5's Care Area Assessment (CAA) for activities of daily living (ADL's)/Rehabilitation Potential, dated 10/6/16, identified potential for decline in ADLs, and need for increased assistance from nursing staff. The CAA indicated the need for care planning to slow or minimize R5's decline, and to maintain current level of functioning.

During observation of morning cares on 1/5/2017 at 7:13 a.m., nursing assistant (NA)-D dressed R5's lower body while still in bed. R5 was able to sit up with assistance, and required limited assistance to lift and move R5's legs to sit up at the side of the bed. While dressing, R5 was able to hold up her arms, slightly below shoulder level, as NA-D placed R5's hands and arms through the shirt arm holes. R5 did not exhibit any pain while dressing, and neither hands nor arms were contracted. NA-D also assisted R5 to transfer from the bed into her wheelchair. With a gait belt in place, R5 grasped the left arm rest of the wheelchair next to the bed, and was able to stand with assistance. During the transfer, R5 was slightly hunched over, but able to bear her weight.

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NA-D assisted to support and maintain balance for R5 as she pivoted, then sat into her wheelchair. No restorative services were provided during morning cares.

In an interview on 1/5/17, at 7:50 a.m. NA-D stated R5 usually required "limited" assistance of one staff for transfers, and getting dressed, and also that R5's participation depended on her hip pain. NA-D stated she did today, nor routinely, work on restorative programs, but was sure R5 had one. NA-D stated there were other aides who did the rehab programs. NA-D also stated she has not seen R5 walk with staff in "more than a month."

R5's care plan, revised 10/7/2016, identified an ADL self-care deficit, related to pain, history of left hip fracture, and included the intervention of a restorative program.

R5's "Restorative Care Program," revised 11/16/15, indicated goals: maintain upper extremity strength and endurance to assist with activities of daily living; maintain lower extremity strength; maintain ability to ambulate; and maintain balance strategies. The program directed the following approaches: 10 times 1-2 pound free weights on bilateral, upper extremities, flex and extend elbow, punch out and internal rotation; sit and use upper extremity bike 5 minutes, with rest as needed; overhead pulley with no weight 3 to 4 minutes; daily walk 60 feet (revised 2/26/16); and NuStep (seated device) level one for 10 minutes.

Nursing Rehab sheets from July 2016 to November 2016 were reviewed and indicated R5's restorative services were provided/refused or unavailable as follows: July, 5x (times), 1x

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refused; August, 3x, 1x refused, 2 x unavailable; September, 5x, 1x refused; October, 6x, 4x refused; November 3x, 2x refusals, 1x unavailable; there was no documentation after November 15th. There was no documentation for December 2016 or January 2017.

During an interview on 1/5/2017, at 2:06 p.m. nursing assistant (NA)-B stated she was one of the rehab aides, and she "dutifully" completed restorative nursing programs with residents. NA-B stated that about November, however, there were no staff available to complete the programs, and she was often "pulled" from rehab assignments to work on the floor, as often as five times a week. NA-B stated R5's restorative goal was five times a week, but "it just didn't get done." NA-B stated it was no surprise there was little or no documentation of the rehab program fro R5 since the middle of November.

In an interview on 1/5/2017 at 2:58 p.m., the director of nursing (DON) stated the Restorative Care Program was part of R5's comprehensive care plan, and it was nursing's responsibility to make sure the program was followed. The DON acknowledged R5's restorative program was not consistently completed for several months, and also lacked documentation that R5's program was completed at all since mid-November. The DON stated it was difficult to find staff to do the programs, especially at the end of the year, and the restorative nursing program struggled. The DON stated she "absolutely" expected R5's, and other residents' care plans be followed, and the restorative nursing programs be implemented.

R15's quarterly MDS, dated 10/19/16, identified no cognitive impairment and needed extensive assistance with mobility and transfers, and had a

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functional limitation of the lower extremity on one side.

R15's ROM/Balance Assessment, dated 7/22/16, identified a left lower extremity impairment related to a previous left hip fracture. The assessment indicated the impairment affected R15's physical functioning, and R15 did not utilize any braces or splints. It further indicated physical therapy ended on 7/21/16, as R15 refused to participate.

R15's ROM/Balance Assessment, dated 10/18/16, identified the same left lower extremity impairment which continued to affect his physical functioning. The assessment indicated the "left leg continues to be stiff and slower with movement," and R15 was not able to completely flex or extend the leg. It indicated R15 was on a Nursing Rehab program for exercises.

R15's Restorative Care Program, dated 9/17/16, included goals of maintaining his ability to transfer for family outings, maintain left lower extremity strength, and to encourage ambulation as tolerated or would agree to. R15's restorative program included using the NuStep (exercise bike), and ROM performing hamstring pullbacks, hip abductions, and hip flexion with varying repetitions.

R15's current care plan, dated 10/25/16, identified R15 had an alteration in ADL's due to "Impaired Balance, Inability to move independently, Impaired LLE [left lower extremity]." Further, the care plan identified several interventions, but there was no indication R15 was on a restorative program or that he refused restorative exercises.

Review of R15's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which

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listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which identified the following entries:

September 2016: R15 had ROM completed seven times, with a, "X" (meaning no staff were available for exercise) being written in six times on the remaining days. R15 was identified as refusing once.

October 2016: R15 had ROM completed nine times, with a, "X" being written in 17 times on the remaining days. R15 was identified as refusing the ROM four times.

November 2016: R15 had ROM completed five times, with a, "X" being written in nine times with the remainder of the form (after 11/16/16) being left blank. R15 was identified as refusing the ROM twice.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

During interview on 1/4/17, at 6:02 p.m. R15 stated he did exercises "when I'm ready," further stating the times he went to exercise varied.

During observation of morning cares on 1/5/16, at 7:11 a.m. registered nurse (RN)-B and nursing assistant (NA)-F were observed assisting R15 to the bathroom. With assistance and a transfer belt, R15 was able to stand from his wheelchair, ambulated a few step, and sit down on the toilet. NA-F proceeded to provide R15 with washcloths. R15 was observed to independently wash his face and upper body. NA-F assisted R15 to dress his upper body, R15 was able to use his upper

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extremities to assist with dressing. NA-F proceeded to put on R15's pants on while he sat on the toilet. After completing morning cares, NA-F placed the wheelchair in the bathroom next to the toilet and, with assistance, R15 grabbed the assistance bar, stood while NA-F pulled up the pants, and sat down in the wheelchair. No restorative exercises were performed during the observation.

During interview on 1/5/17, at 7:34 a.m. NA-F stated it was the first time she had worked with R15 and wasn't aware of any restorative program.

During interview on 1/5/17, at 7:49 a.m. NA-C stated R15 worked with the physical therapist sometimes; however, wasn't sure if R15 was on a restorative program. NA-C stated the restorative programs used to be completed by a few nursing assistants, but hadn't "seen that in a while."

During interview on 1/5/17, at 11:42 a.m. NA-B stated R15 had a restorative program; however, the nursing assistants hadn't had time to complete it for the last couple of months due to staffing. NA-B further stated R15 was "pretty consistent" with doing the restorative exercises. She further stated he came to the restorative program more than he refused, disliked the NuStep, and would occasionally use ankle weights and do stretches.

During interview on 1/5/17, at 11:58 a.m. RN-A stated the facility had two nursing assistants, trained by the the physical therapist, who performed the restorative program. RN-A further states the restorative program wasn't being done "pretty often," depending on the week, because the nursing assistants were not consistently working as restorative aides.

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During interview on 1/5/17, at 12:22 p.m. physical therapist (PT)-A stated R15 had worked with her on the NuStep and with doing a few exercises for his legs. PT-A stated R15 had been more combative with therapy when he was first admitted to the facility, but thought he was being offered restorative exercises and was currently refusing less to perform exercises. In addition, PT-A states "he sporadically wheels himself down (to the exercise room)" to do restorative nursing.

During observation on 1/5/17, at 4:01 p.m. PT-A was observed performing ROM on R15. PT-A reported R15 had no decline in his ROM and had no contractures. PT-A reported the goal of R15's restorative program was to prevent contractures after his previous left hip fracture.

R29's quarterly MDS dated 11/11/16, identified R29 had severe cognitive impairment, was totally dependent on staff for her ADLs, and had impaired functional range of motion (ROM) on both of her upper extremities.

R29's Restorative Care Program dated 5/18/15, identified a goal to, "Maintain ROM to all extremities." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "ROM to all extremities daily as tolerated by resident," with a frequency of "7x/wk."

R29's Nursing Rehab forms dated 9/2016 to 11/2016, identified a flowsheet which listed several columns with 31 separate rows. This sheet provided spacing to record an exercise completed on each day of the month which

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identified the following entries:

September 2016: R29 had ROM completed eight times, with a, "X" being written in 22 times on the remaining days.

October 2016: R29 had ROM completed 12 times, with a, "X" being written in 19 times on the remaining days.

November 2016: R29 had ROM completed five times, with a, "X" being written in 11 times with the remainder of the form (after 11/16/16) being left blank.

There were no further flowsheets to demonstrate any ROM had been attempted or completed after 11/16/16.

R12's quarterly MDS dated 9/14/16, identified R12 had moderate cognitive impairment, required extensive assistance with ADLs, and had impaired functional ROM on both of his upper and lower extremities.

R12's Restorative Care Program dated 12/16/16, identified a diagnosis of, "Joint limitation of movement," and listed a goal to, "Maintain R U/E [right upper extremity] function for self feeding." The sheet provided a space labeled, "Approaches/Recommendations for Implementation of Above Goals," and directed staff to complete, "AAROM [active assisted range of motion] R [right] shoulder," and listed several instructions for staff to follow using weights with R12's flexion and extension exercises. Further, the program identified the restorative program should be completed 4 times a week.

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2 895	Continued From page 33 R12's Nursing Rehab forms were requested, however there were no flowsheets to demonstrate the restorative program had been attempted or completed sine being implemented on 12/16/16. During interview on 1/5/17, at 2:09 p.m. RN-A stated the resident restorative programs had not been completed for what, "Seems like awhile," due to not having enough staff, "The staffing's been difficult with that." Further, RN-A stated residents should have had their restorative programs completed as directed to, "Prevent further loss," of their mobility. A facility policy on restorative nursing program implementation was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could schedule an in-service to address the importance of residents receiving appropriate treatment and services for range of motion limitations. An assessment and appropriate treatment intervention plan could be provided by the staff for these residents. A monitoring program could be established in order to assure an on-going effective rehabilitative program for residents with range of motion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant,	21685		2/13/17

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21685	Continued From page 34 including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a clean and sanitary environment in 2 of 8 resident rooms (A8 and A10), reviewed on the A wing, which had the potential to affect 2 residents who currently utilized these rooms. Findings include: During observation of resident rooms on 1/5/17, at 8:44 a.m. the privacy curtain in room A10 was observed stained and unclean. The staining, from an unknown substance, appeared as dark, brown-colored dots and inch-long marks, on the lower portion of the curtain, which was hanging close to the room door. The curtain in Room A8 was also inspected and observed unclean, with a brownish-colored and faded stain, also on the lower portion of the gathered curtain, near the door. During an environmental tour on 1/5/17, at 1:40 p.m. with the maintenance supervisor (MS) and in the presence of the surveyor, the curtains in room A10 and A8 were reviewed. The MS acknowledged both curtains were unclean and in need of changing and cleaning. In an interview on 1/5/17, at 1:43 p.m. the MS stated the curtains were dirty, that one of the	21685	Corrected.	

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21685	Continued From page 35 residents used the privacy curtain "like a Kleenex," wipe her mouth and added the stain could be vomit. The MS stated rooms were painted, repaired and cleaned top to bottom when a resident moved out, but that on a monthly basis there also was a more detailed checklist used to clean and repair resident rooms. The MS stated when housekeeping goes through the room every day, if they notice an issue, like a dirty curtain, they would fill out a request , and then the MS would go in remove and replace the curtain, and the dirty one would be washed. The MS stated the curtain should have been changed sooner, and stated he could just make is a task to "change out" the curtains on a monthly basis. A facility document, Central Todd County Care Center (CTCCC) Room Inspection List, was reviewed, and indicated privacy curtains were to be checked monthly. A policy regarding the cleaning and maintaining of resident rooms was requested, but not provided during the survey. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the policy for housekeeping. The administrator or designee could perform audits in resident rooms to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21685		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout	21880		1/26/17

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21880	Continued From page 36 their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to act on concerns of cool temperatures in the main dining room for 3 of 3 residents (R18, R20 and R15) who complained of being cold during meal time.

Corrected

Finding include:

R20's quarterly Minimum Data Set (MDS) dated 11/4/16 indicated he was moderately cognitively impaired. The MDS also indicated R20 was able to express ideas and wants, and made himself understood.

R18's significant change MDS dated 9/23/16 indicated R18 was cognitively intact, and was able to express ideas and wants, and made himself understood.

R15's quarterly MDS dated 10/19/16 indicated R15 was cognitively intact. The MDS indicated he was usually understood, had difficulty communicating some words and finishing thoughts, but was able if prompted or given time.

During observation of the noon meal in the main dining room on 1/3/17 at 12: 22 p.m., R18 sat at a table along with R20 and R15. The table was located about 4' (feet) from a north side wall, and in front of a double-pane picture window, about 6' wide by 5' in height. R18, was wearing a sweater, and sat with his back to the window. Left of the window was an 3' wide exit metal and glass door, and a cold draft was felt in front of the door. Also, above the tables along the wall, above where R18, R15 and R20 sat, were heat vents, which

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21880	Continued From page 38 also emitted a cool draft. During an interview on 1/3/17 at 12:38 p.m., R20 stated he usually sits in front of the window (in the main dining room) and even with the shade pulled down, "its damn cold, and I don't like it." R20 stated, it was "always cold" in the dining room and added they forgot to turn off the AC (air conditioning) today. R20 stated staff were aware of his complaint of the cold dining room. In an interview on 1/4/17 at 6:53 p.m., R18 stated when he goes to the dining room, he has to put on another sweater. "It helps, but it's still too cold." R18 stated it had been really cold this winter, especially if there was a south wind. R18 stated he has mentioned his concern about the cold temps to staff in the dining room, and they are well aware of it. During an interview of 1/5/17 at 8:00 a.m., R15 stated the dining room temperature seemed to always be cold, it comes right out of the vent. "It's always cold for me." R15 stated he believed the staff knew about the concern with the cold dining room. During an interview on 1/5/1 at 1:43 p.m., the maintenance supervisor (MS) stated the temperatures in all rooms and parts of the building were checked daily. The MS stated the common areas, like the main dining room were set at 72 deg F (degrees Fahrenheit). On 1/5/17 at 1:43 p.m., with the MS and in presence of the surveyor, the computer-monitored temperature indicated the main dining room temperature was 72.0 deg F. During the same interview, the MS stated he spoke with the administrator about placing plastic	21880		

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21880	Continued From page 39 on the windows by the dining area, but thought this would not work and did not implement this. The MS stated they could just move the residents from the area, since there was plenty of space in the dining room. The MS stated he was aware that residents had expressed discomfort from the cooler temperatures, but they had not done anything to alleviate this complaint. In an interview on 1/5/17 at 3:15 p.m., the director of nursing (DON) stated she and the administrator talked about the window, and the "temps" (temperature) in the dining room. The DON stated she had not heard any specific complaints, but was aware of the problem by the window. The DON stated she did not know if the dietary manager asked anyone about moving or doing some other seating arrangements. The DON acknowledged the dining room can be uncomfortable and stated we'll have to do something. During an interview of 1/5/17 at 3:20 p.m., the administrator stated we could make a change, and change the resident order around in the dining room. The administrator stated it was hard to please everyone, especially when you have residents who've made a choice to sit by the window, but I guess we can make a change. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff on the requirement to address resident concerns and make a good faith attempt to resolve the grievances. The director of nursing could develop a monitoring system to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one	21880		

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21880	Continued From page 40 (21) days. .	21880		