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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 91PN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00235

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245546**

2.STATE VENDOR OR MEDICAID NO.
(L2) **121742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **MISSION NURSING HOME**
(L4) **3401 EAST MEDICINE LAKE BOULEVARD**
(L5) **PLYMOUTH, MN** (L6) **55441**

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 **08/10/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (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
	97			
(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):

Mandatory DOPNA is effective 08/17/2016 is rescinded effective 08/10/2016.

17. SURVEYOR SIGNATURE — Date :
Jennifer Bahr, HFE NE II — 08/10/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/31/2016 (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
02/01/1991
(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
07/26/2016
(L33)

Posted 09/13/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245546
August 31, 2016

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

Dear Mr. Meyer:

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 August 10, 2016 the above facility is certified for or recommended for:

97 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 97 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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 20, 2016

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

RE: Project Number S5546026

Dear Mr. Meyer:

On June 6, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on May 17, 2016 . This survey found the most serious deficiencies to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On July 18, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 14, 2016. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our extended survey, completed on May 17, 2016.

However, compliance with the health deficiencies issued pursuant to the May 17, 2016 extended survey has not yet been verified. The most serious health deficiencies in your facility at the time of the extended survey were found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective August 17, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new

admissions is effective August 17, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 17, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Mission Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 17, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644

Washington, D.C. 20201
(202) 565-9462

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail #7015 0640 0003 5695 6283
August 31, 2016

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, MN 55441

RE: Project Number S5546026

Dear Mr. Meyer:

On June 6, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 27, 2016. (42 CFR 488.422)

On July 20, 2016, this office informed you that the Centers for Medicare and Medicaid Services (CMS) concurred with the following enforcement remedies being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 17, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 17, 2016. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On August 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 10, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on May 17, 2016, as of August 10, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 10, 2016.

However, as we notified you in our letter of June 6, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), as a result of the extended survey your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 17, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of July 20, 2016:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 17, 2016 be rescinded as of August 10, 2016. (42 CFR 488.417 (b))

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

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

Feel free to contact me if you have questions.

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

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PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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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(s)
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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245546 Y1	A. Building B. Wing Y2	8/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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 F0246	Correction	ID Prefix F0248	Correction	ID Prefix F0250	Correction
Reg. # 483.15(e)(1)	Completed	Reg. # 483.15(f)(1)	Completed	Reg. # 483.15(g)(1)	Completed
LSC	07/28/2016	LSC	08/01/2016	LSC	05/18/2016
ID Prefix F0278	Correction	ID Prefix F0312	Correction	ID Prefix F0323	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(h)	Completed
LSC	08/01/2016	LSC	08/01/2016	LSC	08/05/2016
ID Prefix F0325	Correction	ID Prefix F0334	Correction	ID Prefix F0406	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.45(a)	Completed
LSC	06/27/2016	LSC	07/27/2016	LSC	08/10/2016
ID Prefix F0441	Correction	ID Prefix F0490	Correction	ID Prefix F0493	Correction
Reg. # 483.65	Completed	Reg. # 483.75	Completed	Reg. # 483.75(d)(1)-(2)	Completed
LSC	07/29/2016	LSC	07/01/2016	LSC	05/20/2016
ID Prefix F0496	Correction	ID Prefix F0497	Correction	ID Prefix F0501	Correction
Reg. # 483.75(e)(5)-(7)	Completed	Reg. # 483.75(e)(8)	Completed	Reg. # 483.75(i)	Completed
LSC	07/25/2016	LSC	07/29/2016	LSC	07/21/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	PK/KJ	08/31/2016	32209	08/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245546 Y1	A. Building B. Wing Y2	8/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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 F0520	Correction				
Reg. # 483.75(o)(1)	Completed				
LSC	05/27/2016				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/17/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245546 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/18/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0050	06/25/2016	LSC K0056	07/14/2016	LSC K0064	07/07/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0071	05/17/2016	LSC K0072	06/30/2016	LSC K0144	05/17/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0154	06/29/2016	LSC K0155	06/29/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 08/31/2016	SIGNATURE OF SURVEYOR 37009	DATE 07/18/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/10/2016

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00235 Y1	A. Building B. Wing Y2	8/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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	20190	Correction	ID Prefix	20255	Correction	ID Prefix	20300	Correction
Reg. #	MN Rule 4658.0060 B.	Completed	Reg. #	MN Rule 4658.0070	Completed	Reg. #	MN Rule 4658.0105	Completed
LSC		08/01/2016	LSC		08/01/2016	LSC		08/01/2016
ID Prefix	20302	Correction	ID Prefix	20550	Correction	ID Prefix	20830	Correction
Reg. #	MN State Statute 144.6503	Completed	Reg. #	MN Rule 4658.0400 Subp. 4	Completed	Reg. #	MN Rule 4658.0520 Subp. 1	Completed
LSC		08/01/2016	LSC		08/01/2016	LSC		08/01/2016
ID Prefix	20850	Correction	ID Prefix	20920	Correction	ID Prefix	21230	Correction
Reg. #	MN Rule 4658.0520 Subp. 2 D	Completed	Reg. #	MN Rule 4658.0525 Subp. 6 B	Completed	Reg. #	MN Rule 4658.0700 Subp. 2 B	Completed
LSC		08/01/2016	LSC		08/01/2016	LSC		08/01/2016
ID Prefix	21375	Correction	ID Prefix	21426	Correction	ID Prefix	21435	Correction
Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed	Reg. #	MN Rule 4658.0900 Subp. 1	Completed
LSC		08/01/2016	LSC		08/01/2016	LSC		08/01/2016
ID Prefix	21495	Correction	ID Prefix	21510	Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.1005 Subp. 5	Completed	Reg. #	MN Rule 4658.1200 Subp. 2 A.B.	Completed	Reg. #		Completed
LSC		08/01/2016	LSC		08/01/2016	LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	PK/KJ	08/31/2016	32209	08/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/17/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 91PN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00235

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245546**

2.STATE VENDOR OR MEDICAID NO.
(L2) **121742900**

3. NAME AND ADDRESS OF FACILITY
(L3) **MISSION NURSING HOME**
(L4) **3401 EAST MEDICINE LAKE BOULEVARD**
(L5) **PLYMOUTH, MN** (L6) **55441**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/17/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **97** (L18)

13.Total Certified Beds **97** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	97			
(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):
Mandatory DOPNA is effective 08/17/2016.

17. SURVEYOR SIGNATURE Date :
Annette Truebenbach, HFE NE II 07/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 07/21/2016 (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
02/01/1991
(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 07/26/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6139
June 22, 2016

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, Minnesota 55441

RE: Project Number S5546026, H5546050

Dear Mr. Meyer:

On May 17, 2016, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 17, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5546050 that was found to be unsubstantiated.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to

resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 17, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore,

this Department is imposing the following remedy:

- State Monitoring effective June 27, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

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

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mission Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 17, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of

care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

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

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

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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

If substantial compliance with the regulations is not verified by August 17, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

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(s)
cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Submitted
June 6, 2016

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, Minnesota 55441

RE: Project Number S5546026, H5546050

Dear Mr. Meyer:

On May 17, 2016, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered. In addition, at the time of the May 17, 2016 extended survey the Minnesota Department of Health completed an investigation of complaint number H5546050 that was found to be unsubstantiated.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate

jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on May 17, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore,

this Department is imposing the following remedy:

- State Monitoring effective June 11, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

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

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Mission Nursing Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 17, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of

care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 17, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 17, 2016 (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, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING _____ B. WING _____	05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(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 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. A survey was conducted by the Minnesota Department of Health on 5/9/16 through 5/17/16. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failed response to comprehensively assess and develop appropriate interventions related to unsafe alcohol use and lack of monitoring when residents were intoxicated, which resulted in the high potential for harm or death. The IJ began on 7/1/15, when it was identified R51 had an extremely elevated breathalyzer reading and clinical symptoms without appropriate intervention. The IJ was removed on 5/17/16, at 2:30 p.m. when the facility implemented interventions including assessing the residents' safety, implementing/enforcing appropriate interventions, educating staff, and updating policies/procedures. An extended survey was conducted by the Minnesota Department of Health on 5/12/16 through 5/17/16.	F 000	Mission Nursing Home objects to and disagrees with both the findings of non-compliance and the level of deficiency cited. We do not believe that the conditions at Mission constitute "actual harm". This Credible Allegation of Compliance has been prepared & timely submitted. Submission of this Credible Allegation of compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the facility, it's Administrator or any employees, agents or other individuals who draft or may be discussed in the Credible Allegation of Compliance. In addition, preparation & submission of the Credible Allegation of Compliance doe not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the State-ment of deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance with in this time frame should not be considered	

7/21/16 accepted

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

[signature] ADMINISTRATOR 7/20/16

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

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F 000	Continued From page 1 At the time of the recertification survey an investigation of complaint H5546050 was completed and found not to be substantiated.	F 000	or construed as agreement with the allegations of non-compliance or admissions by the facility. It is the policy of this facility to provide each	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess preference of facial hair for 1 of 2 residents (R38) reviewed for choices. Findings include: R38 was admitted to the facility on 5/21/15. R38's quarterly minimum data set (MDS) dated 2/16/16, identified R38 had moderate cognitive impairment. Further more, R38's MDS identified him as having Alzheimer's disease, receiving hospice care, and requiring extensive physical assistance with personal hygiene. R38's care plan dated 4/26/16, identified a self care deficit in ADL's requiring one staff to assist with grooming. It further specified for staff to "Encourage to wash his face and hands.". The care plan did not specify any preferences in the cares provided with grooming.	F 246	resident with reasonable accommodations to meet their individual needs and preferences. To assure continued compliance the following plan has been put into place: 1. Develop Preference Assessment Related to care including shaving/facial hair. R38 will be done immediately . 2. Current residents will be assessed on or before 7/29/2016. New admissions will also be assessed. 3. Nurse Manager will ensure care preference observation is completed with each admission MDS, and provide information on care plan & assignment sheets. 4. DON or designee will audit assessment compliance, reflection to care plan, assignment sheets, and report findings to QA. Audit outcomes will be reported to the QA committee by 7/21/2016 for review for compliance and/or development of an action plan for further issues. Responsible: Nurse Manager, DON	7/13/2016 7/21/2016

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F 246	Continued From page 2 R38's face sheet included an admission photo in which R38 had a thick white and gray mustache. On 5/9/16, at 7:00 p.m. R38 was observed sitting in his wheelchair. White hairs, approximately 1/8" (inch) long, were noted on his upper lip and scattered on both cheeks. On 5/10/16, at 11:33 a.m. R38 was observed with the same white hairs on his upper lip and scattered on both cheeks. The stubble was approximately the same as the day before. On 5/11/16 at 8:24 a.m. family member (F)-A expressed concerns that R38 was not being shaved often enough. F-A further thought that R38 was only receiving assistance with shaving once a week. F-A stated that shaving was very important to R38, who had been "the most particular person you can imagine" regarding shaving. FA-1 went on to state that shaving "was a huge thing for him." F-A stated R38 always kept his mustache in his younger years and would "not feel good" about the mustache being shaved. On 5/11/16, at 7:14 a.m. R38 was again observed sitting in his wheelchair, waiting by a medication cart. R38 continued to have white facial hair on his upper lip and cheeks. The hair on R38's upper lip and cheeks was longer than when observed on 5/9/16 and 5/10/16. On 5/12/16, at 7:43 a.m. R38 was observed sitting in wheelchair eating breakfast in the dining room. His hair appeared wet and had been combed. R38 stated he had had a bath that morning. The white hair on his upper lip and cheeks was now approximately 1/4" long.	F 246		

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F 246	Continued From page 3 On 5/13/16, at 10:10 a.m. nursing assistant (NA)-M stated R38 received grooming, bathing, and shaving assistance from the hospice aides and the facility nursing assistants. NA-M stated shaving was the responsibility of the facility nursing assistants, not hospice. NA-M stated R38 had his own razor and there was a floor razor for resident use as well. NA-M stated R38 never refused offers to shave and NA-M shaved him that morning. NA-M reported that shaving was a routine, some residents would say yes or no, some would say "go right ahead." Later that same day at 11:29 a.m. R38 was observed sitting in his wheelchair looking out the window. His face was clean shaven, including the hair on his upper lip. R38 was stated he did not like having a beard but "a mustache I like." On 5/13/16, at 1:39 a.m. licensed practical nurse (LPN)-B stated R38 was shaved by both hospice and facility staff and went on to state that most residents were shaved every third day. LPN-B stated nursing staff would shave a resident if they needed it because they would "see it [facial hair]." LPN-B further stated residents' care plans identified how often they needed to shaved or groomed. On 5/16/16, at 10:38 a.m., LPN-A stated shaving was suppose to be a daily event and was included in grooming. LPN-A was unaware of any assessment regarding facial hair and whether or not a resident wanted to keep a mustache.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program	F 248		

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F 248	Continued From page 4 of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide meaningful activities for 1 of 3 residents (R16) reviewed for activities. Findings include: R16's care plan dated 4/14/16, indicated R16's diagnoses included schizoaffective disorder, Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). An annual Minimum Data Set (MDS) dated 5/6/16, indicated R16 had severe cognitive impairment. It also indicated R16 felt it was very important to listen to music, have newspapers/magazines to read, to do things with groups of people, and important to go outside and get fresh air. A quarterly MDS dated 2/5/16, indicated R16 was independent with ambulation. R16's care plan directed staff to invite and encourage R16 to attend upcoming programs of interest such as televised sporting events, socials and special events. A Therapeutic Recreation Interest Survey dated 5/15/15, indicated some of R16 interests included smoking, cards, Bingo, painting, sports, newspapers, music, and television. An activity calendar dated 5/16, indicated some of the activities that were planned included Bingo,	F 248	Mission strives to meet the interests; physical, mental and psychosocial needs of each of the resident through structured activity programs. TR Director re-educated staff on the importance of documenting resident being offered programs, attendance and refusals. This was completed through review of job descriptions & department policies including basic facility policy "Steps to follow each time when running a program" dated 2/14. TR Director established a computerized program for attendance for the activities for the whole house with every five (5) day interval highlighted. That is to ensure that each resident is seen at least one time within that 5 day period, preferably more. TR staff continues to monitor whether residents are active or passive participants in programs and whether they refuse programs. R16's refusal and /or attendance was not documented. However, in June, R16 refused 16 programs, regularly attended monitored smoking program and also went to the barber, attended a reading group and a social. In May R16 refused 18 programs regularly attended monitored smoking program, interacted with staff & peers 2 times, and participated in traveling program one time.	6/30/2016

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F 248	Continued From page 5 morning music, creative arts, movies, gardening, and cards. A daily activity log dated 5/1, 5/3, 5/5, 5/6, 5/9, 5/10, and 5/11/16 did not indicate R16 was asked to participate in the activities, if R16 refused activities, or if R16 attended any activities. On 5/11/16, at 2:37 p.m. R16 was observed smoking with other residents in the second floor smoking room. At 3:23 p.m. R16 was sitting in the dining room with a view of the smoking room. R16 was not observed in any group or individual activity. On 5/11/16, at 3:25 p.m. with R16 stated he went to activities when they were offered. R16 got up from the chair in the hallway and walked into the smoking room when it was opened. R16 stated he was going to have a cigarette now. On 5/11/16, at 3:28 p.m. the director of activities (DA) stated resident's needed a lot of encouragement to try things in their rooms and on thier own. The DA stated every resident should be invited to the activities. The DA stated if R16 were approached for an activity then it should be documented on the activity log. The DA stated there is a big problem here with documentation. A facility policy Basic Activity Program-Steps to Follow Each Time When Running a Program dated 2/14 directed staff to document the participant's involvement in the activity.	F 248	TR staff will continue to utilize individual interest surveys that are completed on all residents (on admission and annually) to determine which activities are considered by the resident to be meaningful and guide them in what to invite him to. TR staff will complete a current assessment on each resident to what activities each individual finds meaningful. Director of TR will conduct random audits weekly to ensure that TR staff is offering and encouraging residents to attend activities that they chose as meaningful. A summary of changes to policy to ensure that residents are being invited to meaningful activities and audit results will be discussed at QA meeting. Audits will be on-going until QA determines compliance. Responsible: TR Director	8/1/2016
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		

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F 250	Continued From page 6 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide medically related social services for residents who abuse alcohol, to ensure consistent implementation of established facility protocols and/or to assist with discharge planning for 2 of 3 residents (R11 and R51) reviewed for alcohol use and other behaviors. Findings include: When interviewed on 5/17/16, at 12:50 p.m. the social services director (SSD) stated part of her role with chemically dependent residents is determining their history. The SSD stated during the initial care conference, she lets the interdisciplinary treatment team (IDT) know what is appropriate for the individual resident. The SSD acknowledged if residents drink "too much" they could be a danger to themselves or others, but was unable to define what "too much" was, she stated "definitely if they get alcohol poisoning, or if [R51] would have a seizure, that would be too much." R11's quarterly Minimum Data Set (MDS) dated 3/8/16, identified admission to the facility on 3/1/02. It also identified R11 had modified independence with cognitive skills for daily decision making, and demonstrated feeling down, depressed or hopeless. R11 was noted to be independent with activities of daily living (ADLs).	F 250	Revised alcohol drug use policy to include consequences of alcohol use on LOA, may include breathalyzing, room searches- (now states that any room may be searched if anyone is suspected of having alcohol), person searches, adjusting monitoring level. Refusal to submit to a breathalyzer, in-house alcohol consumption (outside of the Gazebo program) or returning from an LOA intoxicated will trigger a resident's current set of parameters (restrictions) to the next higher level based on their individual circumstances. An alcohol related infraction will trigger moving up one or more monitoring levels for one week and then will be re-evaluated by IDT. IDT will evaluate and monitor all alcohol related incidents at each morning meeting to ensure policy is being adhered to. Responsible Director of Social Service (DSS) Quality assurance committee review at next meeting and on-going.	5/18/16

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F 250	Continued From page 7 Active diagnoses included diabetes mellitus, non-Alzheimer's dementia, anxiety, depression, cognitive communication deficit, alcoholic cirrhosis of liver, and alcohol dependence. The MDS also identified R11 exhibited other behavioral symptoms not directed toward others, and rejection of care. R11's behavioral symptom Care Area Assessment (CAA) dated 7/2/15, identified R11 had episodes of impaired judgment and poor decision making, noting an episode in which he was in a verbally aggressive altercation with another resident which lead to threatening and physical aggression. "He also has been warned about not going out into the community to drink alcohol or take drugs and/or bring anything back in with him." The CAA documentation lacked any direction or guidance in dealing with these behaviors. R11's medical record lacked a comprehensive assessment related to safety of alcohol use. R11's medical record lacked a signed Alcohol and Drug Use policy. The face sheet identified R11 as his own responsible party. R11's care plan dated 4/8/16, identified a potential alteration in cognition related to alcohol dependence. It also identified a history of going out 'for a few drinks'. Interventions included: encouraging sobriety, Level I monitoring (date initiated 12/11/11), private room due to inability to get along with roommates, and identifying physical and verbal aggression. The care plan also indicated R11 was at moderate risk for falls due to alcohol or drug use. Interventions included: independent with transfers, and observe	F 250	Selected residents (R51, R11, will sign the revised alcohol policy. Current residents/ guardians will also be signing the updated policy by 8/1/2016. Responsible: DSS Develop individualized resident alcohol related plan of care for R51, R11, (on-going risks of drinking with their diagnosis, praising for policy compliance, breathalyze upon return to facility, search upon every return to the facility) Responsible: DON, Nurse Managers, DSS R51: Goal: will comply with MNH alcohol policy through next review. Ensure R51 has no containers in his wheelchair when going down for Gazebo program. Follow Intoxication/Impairment Assessment Tool and care track indicated as needed. Praise R51 for compliance with alcohol policies. Remind R51 about the rules r/t alcohol in and out of the Gazebo program. Room check random and when suspicion of alcohol possession. Search R51 upon reentry into building. Include looking in socks. When intoxicated encourage R51 to drink water and Gatorade, eat food and rest. Ongoing monitoring for seizure activity d/t history of alcohol withdrawal related seizures.	5/18/2016

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F 250	Continued From page 8 orthostatic blood pressure monthly. The care plan lacked specific interventions related to alcohol use. The facility provided a Resident Classification Listing by Room dated 4/18/16. R11 was identified as a Level II (which contradicted information provided on the care plan). On 5/16/16, at 10:01 a.m. the social service director (SSD) was asked about the conflicting level information for R11. The SSD stated she was unsure why R11 was a Level II on the Resident Classification Listing. The SSD stated, [R11] "is a Level I, and has been since 9/23/12. Everyone knows this." R11's Fall/Safety Risks Evaluation and Assessment dated 3/7/16, failed to indicate R11 had a current issue with alcohol and/or drug use, an extensive history of alcoholism, alcoholic cirrhosis of the liver, drunkenness, and alcohol-induced persisting dementia. The assessment indicated "occasionally resident is confrontational with staff and other residents, especially if drinking alcohol." Review of R11's progress notes dated 4/22/15 through 5/14/16, identified the following incidents: - 5/4/15, at 10:24 p.m. R11 went for a walk at 6:55 p.m., and returned at 9:10 p.m. Refused breathalyzer, stating, "I'm not on the Gazebo program. I don't have to do that anymore." (The facility's Gazebo Alcohol Program [A program run by the facility, which allows residents to drink a physician approved, set amount of alcohol provided by staff, in a specific area of the building at a specific time each day]).	F 250	R11: Goal: R11 will allow Intoxication/ Impairment Assessment Tool when indicated through next review Breathalyzer on any return to facility. Follow Intoxication/Impairment Assessment Tool protocol when alcohol use is known or suspected. Observe for and document any symptoms of alcohol use per Intoxication/Impairment Assessment Tool. Ongoing education regarding risks of continued alcohol consumption on health and safety. Random room search and for suspicion of possession of alcohol. Search for any alcohol upon return to facility. Search to include checking socks. When R11 is intoxicated encourage water or Gatorade intake, food intake and rest.	

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F 250	Continued From page 9 - 5/23/15, at 3:50 a.m. R11 exited his room, agitated, jumping from one subject to another, at times not making sense, talking about drinking in his room. - 5/23/15, at 9:45 a.m. R11 had been speaking to staff in a "foul language". It also noted R11 shared with dietary staff he had been drinking. The documentation included: "In a brief glance around room do not see any alcohol bottles/containers." - 5/24/15, at 3:30 a.m. identified at 9:50 p.m. R11 was observed blocking the door entrance, with the door monitoring staff outside. R11 began yelling racial slurs to staff and threatening to "physically harm the door monitor." R11 walked toward staff in a threatening manner, swearing, and was informed if he physically harmed staff, the police would be called. R11 went to his room, and returned at 10:05 p.m. cursing, gritting his teeth, and leaning on the nursing station. He was informed the police would be called if he didn't calm down. It was also noted R11's eyes were "extremely blood shot." R11 was checked on x 2 [twice] and appeared to have calmed down. - 6/17/15, at 12:00 p.m. R11 confronted and had a verbal altercation with a peer, and when being escorted out of the dining room, began to threaten the peer, making the motion of a fist, and attempted to get back in the dining room. The note indicated R11 had slurred speech and suspected he had been drinking. R11 stated, "Did he laugh at me, I'm gonna knock the shit out of him." A corresponding incident report dated 6/16/15 was completed, but lacked any additional content.	F 250		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 10 - 6/17/15, at 5:55 p.m. the SSD and administrator discussed recent behaviors with R11, and he was informed he could not drink in or out of the building unless in the gazebo program. The notes indicated if the resident gets intoxicated he has to cooperate with the nurses when they ask for a breathalyzer and if he doesn't comply he will be sent to the hospital and/or the police will be called to assist. He stated that he understood and certainly did not want the police called due to his behaviors. Finally he was told that he will be given a notice to discharge if there are any more incidents, he responded with "I am leaving soon anyway" and when asked where he was going he could not give an answer. The documentation indiated the administrator had reiterated everything one final time and the resident had verified he understood. A couple of hours later the resident had asked whether if they would find him a place to go if given a discharge notice. - 6/19/15, at 9:30 a.m. (documented as a late entry) identified R11 was told that he would be given notice to leave if his behaviors continued. - 7/5/15, at 5:36 p.m. R11 had a verbal altercation with a peer, threatening to "beat each other up." Four staff intervened until the peers walked away from each other. - 7/7/15, at 7:46 p.m. R11 was in a verbal altercation with a peer, entering peer's room, yelling and cursing at peer. - 7/10/15, at 3:12 p.m. R11 complained of abdominal pain, and an abdominal x-ray was ordered. R11 stated, "Don't send them in my room, I'll kill them."	F 250	Revise the Resident Monitoring (Level) Policy to include initial placement at a level IV, individual circumstances may warrant a level change and how staff will be notified of changes. Greater restriction (monitoring) will occur for non-compliance, lesser restrictions (monitoring) for compliance with the program. Responsible: SSD	5/18/2016

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	245546	A. BUILDING _____ B. WING _____	05/17/2016

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F 250	Continued From page 11 -8/20/15, at 1:24 a.m. R11 was complaining about issues to staff. He then began cursing and became agitated. - 9/4/15, at 4:32 p.m. staff reported to nurse R11 appeared to be drunk. The SSD and administrator entered R11's room with the breathalyzer. When asked if he had been drinking last night or this morning, R11 denied it. His speech was somewhat slurred. Breathalyzer read 0.204, and a retest of the breathalyzer was 0.203. "This writer and Administrator then reminded him of a discussion in which he stated that he understood that if an incident like this happened again he would be given a notice to leave. He said that he remembered this. This writer then informed him that a referral would be made for the Glennwood, (wethouse) [a residential facility for chronically alcoholic and homeless men and women], so that discharge planning could begin. He stated understanding of this." - 9/8/15, at 10:22 p.m. R11 was found on the floor near the door in his room. He appeared drunk but refused breathalyzer and vital sign assessment. Resident stated "don't call the police I am already in trouble." Corresponding incident report completed, identified plan to "possibly" give resident a 30 day notice to discharge. - 9/9/15, at 5:44 p.m. Staff reported R11 appeared drunk. SSD and another staff entered R11's room. R11 refused breathalyzer. He was informed if he did not do the breathalyzer, "it was the same as saying that he had been drinking." R11 continued to refuse, and closed his eyes.	F 250		

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F 250	Continued From page 12 - 10/19/15, at 6:15 p.m. R11 left facility at 8:30 p.m. and returned at 9:50 p.m. Breathalyzer read 0.105. - 10/23/15, at 10:19 p.m. R11 went out from 5:45 p.m. - 9:35 pm. Breathalyzer read 0.162. - 10/31/15 at 7:15 p.m. R11 had a verbal altercation with housekeeping. A corresponding incident report completed on 10/31/15 lacked any further information. - 11/7/15, at 7:27 p.m. R11 went out at 6:50 p.m., returning at 7:11 p.m. Breathalyzer read 0.022. - 11/9/15, at 9:45 p.m. R11 left at 8:00 p.m., and returned at 8:50 p.m. Breathalyzer read 0.077. - 11/16/15, at 12:30 a.m. R11 to the nurses station asking for medication he had previously refused. He became "very upset and began cursing". Staff attempted to talk with R11, but he refused to listen and walked off to his room. - 11/16/15, at 6:30 p.m. R11 out of the building from 6:30 p.m. - 8:30 p.m. Breathalyzer was 0.08. - 11/19/15, at 10:54 p.m. R11 out of the building and breathalyzer read 0.06 upon return. When interviewed on 5/11/16, at 4:21 p.m. the DON stated breathalyzer was below the legal limit, and she wouldn't expect any increased monitoring. The DON stated she was not notified, and would expect herself or the SSD to have been notified of any incident involving drinking of any amount, and would expect an incident report	F 250		

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F 250	Continued From page 13 completed. - 12/24/15, at 5:30 p.m. R11 was found with two cans of beer in his room, observed to be dumping it down the drain when staff entered. R11 began cursing, slammed the cabinet door shut with his foot. On 5/11/16, at 4:21 p.m. the DON stated no breathalyzer was done. The DON also stated a room search revealed no further alcohol, and she was notified of this incident. There were no further symptoms, and she would not expect 15 minute checks. Further, the DON stated R11 was aggressive, but he was also aggressive without alcohol. - 3/29/16, at 9:13 p.m. R11 left the facility at 6:20 p.m. and returned at 9:20 p.m. R11 reported being down by the lake, and breathalyzer reading was 0.143. - 4/13/16, at 9:06 p.m. R11 left the building and refused breathalyzer upon return. - 5/7/16, at 6:40 p.m. R11 left the facility at 2:05 p.m. and returned at 6:39 p.m. Breathalyzer read 0.256. Resident went to his room. On 5/11/16, at 4:21 p.m. the SSD stated R11 was not on the Gazebo program because he didn't want to follow the rules, and it was 'his right to drink'. The DON also verified that on 5/7/16 when R11's breathalyzer reading was so high, R11 had gone to his room. The DON was unable to provide any documented assessment at that time such as vital sign readings, or increased clinical and safety monitoring having been done. The DON stated she would have expected an incident	F 250		

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F 250	Continued From page 14 report and 15 minute checks to have been completed. R11's Social Services Review notes dated 3/10/16, identified "He does display some short term memory deficits some of which could be selective memory. He has episodes of impaired judgement." The notes also included, "He can also be verbally aggressive towards staff especially when they want him to do something. He does not want anyone in his room even after knocking. He has episodes of drinking inside or outside of the building and then denying that he has. Social Service will remain actively involved through 1 to 1 visits and behavior management interventions as needed." During interview with the SSD, she stated the original plan for R11 was to discharge him to a wethouse [a residential facility for chronically alcoholic and homeless men and women]. However, he was not accepted there because he has a colostomy, and even though he is independent with the cares of his colostomy, there was a concern from the wethouse about shared bathrooms. The SSD verified the nursing home was not an appropriate placement for R11, as he requires no skilled care, and stated she had been trying to convince him to go to a more independent setting, but stated there was no current plan in place for discharge. The SSD stated on 5/17/16 at 12:50 p.m., that R51 remained adamant he wanted to continue to drink, and that a reason he wanted to come to this nursing home was to be a part of the alcohol program. The SSD verified no discharge plans were in progress for this resident.	F 250		

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F 250	Continued From page 15 R51's quarterly MDS dated 4/28/16, identified the resident had modified independence in cognitive skills for daily decision making, behavioral symptoms not directed toward others, and required the use of a wheelchair. Diagnoses included hypertension, diabetes mellitus, seizure disorder/epilepsy, and depression. R51's CAA dated 11/3/15, identified diagnoses of acute alcohol intoxication/withdrawal, physical weakness, depression, limited range of motion, poor coordination, poor balance, and visual impairment. It also identified behavior problems including disruptive, loud talking in the dining room "especially after Gazebo/alcohol program." The CAA noted impaired balance during transitions, and difficulty maintaining sitting balance as well as agitation and decreased mobility. The CAA lacked any direction or guidance in dealing with these behaviors. R51 did not have a comprehensive assessment related to the safe use of alcohol. R51's medical record included a signed contract to participate in the Gazebo program dated 8/7/15. However, there was not a signed Alcohol and Drug Use policy. The face sheet identified R51 as his own responsible party. R51's care plan dated 4/27/16, identified a self care performance deficit related to alcohol use. It also identified R51 had a potential risk for falls related to being wheelchair bound, and the use of alcohol with the Gazebo program. The plan of care indicated both long and short term memory problems, and poor judgement and decision making due to alcohol dependence. The care plan also identified an alteration in mood and behavior related to acute alcohol	F 250		

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F 250	Continued From page 16	F 250		

intoxication/withdrawal. Interventions included to remind of the rules around the gazebo/ alcohol program. The care plan failed to identify R51's alcohol monitoring level.

The Resident Classification Listing By Room form, dated 4/18/16, identified R51 as a Level III.

Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following:

A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility."

- On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo program. "Client monitored closely". Blood pressure upon waking is 75/54 and heart rate 75. Given meal tray and drank 300 ml (milliliters) of water. Blood pressure at 6:30 p.m. 87/53. Physician notified and orders received to check blood pressure every four hours and continue to encourage fluids. Other notes from this date identified resident left at 10:35 a.m. with his niece and returned at 1:05 p.m. He was searched and breathalyzer was 0.258. Staff found a bottle of whiskey in his room, which was locked in the liquor cabinet. An incident report was completed for this incident on 7/1/15, noting "Resident was instructed to not drink." The record lacked evidence their Gazebo policy was followed.

On 5/11/16, at 3:02 p.m. the SSD stated, "if they mess up like this when in the program, they would be suspended for 3 days, or a week if they

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F 250	Continued From page 17 are sent to the hospital or detox." - On 7/2/15, at 10:48 a.m. a note indicated R51 had been seen by the nurse practitioner, and the note indicated R51 is an adult and can drink and smoke when he wants. "He is not hurting himself or anyone else." - On 7/2/15, at 1:59 p.m. a note identified R51 was on a three day suspension from the Gazebo program. A Physician Progress note for R51 dated 7/2/15, identified the chief complaint as alcohol intoxication. It noted resident had a breathalyzer reading of 0.258, and blood pressure was noted to be low at 87/56, with a retake at 75/54. The note indicated during interview with the physician the resident had stated, "I am fine, I went out with someone and had some drinks. I am an adult and I will do whatever I want. I am here because I can drink and smoke. If I get the opportunity again, I will do it. I am not hurting myself or anyone else when I drink, so I should be left alone." The nursing progress notes indicated R51 was allowed to sleep it off, there was no report of aggressive behavior towards staff and included, "Patient will be off Gazebo program for three days. Nursing will continue to monitor for any sign of withdrawal." - On 7/8/15, at 1:20 p.m. the notes indicated R51 was restricted from the gazebo program due to having the bottle. - On 8/6/15, at 10:11 p.m. notes indicated the resident had left with his niece at 2:15 p.m. and returned at 3:45 p.m., appearing drunk and very talkative. "Social worker notified, and resident will	F 250		

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F 250	Continued From page 18 be monitored." It was also documented R51 had refused the breathalyzer as well as other assessments. The record lacked evidence the Gazebo policy was followed. - 8/17/15, at 3:51 p.m. resident left after the Gazebo program in a taxi at approximately 3:13 p.m., attempting to take a peer with him. The documentation indicated the SSD had attempted to stop the resident, but he'd left anyway and had returned at approximately 3:46 p.m. with a brown paper bag, and a bottle of alcohol in it. The notes indicated staff had taken the bag, and the resident was verbally abusive toward staff. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m. the DON stated the alcohol was taken from R54 and locked up in a cabinet. A Code B (a behavior that cannot be controlled, where all available staff come to help) was called since R54 was following the staff and threatening her. When the nurse went in, R54 was intoxicated, slurring his words. Breathalyzer at this time was 0.336, and his blood pressure was running low. The on call physician was called, and instructed staff to monitor resident, encourage fluids, and to call back if there was a decline. - On 8/17/15, at 11:10 p.m. noted resident was examined by a registered nurse in his room at approximately 7:25 p.m. He was "clearly intoxicated, fatigued, and slurring his words." Breathalyzer was 0.336. Blood pressure 94/59 and 86/54. Physician notified and orders received to monitor resident and encourage fluids. Call back with a decline. At 10:00 p.m. blood pressure was 146/82. Also noted at this time to be more	F 250		

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F 250	Continued From page 19 awake, not slurring words, and drinking fluids. The record lacked evidence the Gazebo policy was followed. - On 8/18/15, at 2:57 a.m. noted at approximately 12:15 a.m. staff attempted to obtain vital signs, and resident was increasingly agitated, using foul language. Noted staff obtaining frequent checks on resident every one to two hours for safety. A Physician Progress Note dated 8/21/15, identified a review of the incident [dated 8/17/15] where resident returned to the facility and had a breathalyzer of 0.33. The note indicated the vital signs were now normal and resident is back to his baseline. During interview with the physician, R51 stated he was "angry that the social worker can not allow him to bring his own 'Booze' into the facility. He was also angry that he will be off the Gazebo program for 3 days since he got himself intoxicated." The progress note identified no education and no orders were provided for increased monitoring when R51 was intoxicated. Then note indicated nursing was to continue to monitor for any signs or symptoms of withdrawal. - On 9/28/15, at 10:36 p.m. resident returned to the facility via taxi at approximately 6:00 p.m. and was met at the door by the SSD. He turned in his alcohol bottles, and breathalyzer was 0.141. Resident was informed by the SSD he will not be attending Gazebo tomorrow. On 5/11/16, at 3:02 p.m., the SSD stated R51 liked to go out and drink with his meals. She verified the Gazebo policy identified that drinking outside the program would result in a one week suspension, which had not been enforced in this case.	F 250		

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F 250	Continued From page 20 - On 10/24/15, at 1:33 p.m. notes indicated R51 had refused to shower the evening before, and had been informed he could not attend the Gazebo program, so had become very upset and angry. - On 11/5/15, at 11:24 p.m. identified R51 had returned at 5:35 p.m. from going out on a visit with his brother [left at 12:05 p.m.] The note indicated he was drunk and went to his room after being searched. The record lacked evidence the Gazebo policy having been implemented. On 5/11/16, at 3:02 p.m. the SSD stated there should have been a restriction for not following the gazebo contract. - On 12/4/15, at 10:26 p.m. the notes indicated R51 had gone out at 12:05 p.m. At approximately 6:00 p.m. a call had been received about the resident being drunk at a local liquor store, and being under supervision of the police. R51 had been sent to the hospital. The hospital visit note dated 12/4/15, indicated R51 had arrived via ambulance. "Report that patient was outside a liquor store in Plymouth with intoxication. Police were called. Arrives with appearance of intoxication and slurring words. Patient is wheelchair bound. Reportedly lives at Mission detox center." Further information included, "Patient was conversing in room when he had loss of consciousness on the cart lasting about 30 seconds. Patient unresponsive to sternal rub. Came to after 30 seconds and started yelling incoherently." The last note from this visit identified "Pt [patient] increasing agitation; numerous requests for his belongings and to be allowed to leave. MD [physician] in room	F 250		

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F 250	Continued From page 21 speaking with pt." On 5/11/16, at 3:02 p.m. the DON stated dispatch had called the facility regarding the 12/4/15 incident. The SSD also stated R51 had gone out to eat, and the restaurant was across from a liquor store. The SSD stated R51 had left the restaurant and gone to the liquor store. Staff at the liquor store had subsequently called the police, reporting someone intoxicated. The SSD stated the facility did not have a copy of the police report. The DON stated she'd instructed dispatch to take R51 to the hospital for evaluation. Upon return to the facility after six hours, R51 had refused the breathalyzer or vital signs. The DON said R51 had been demanding staff call the police and hospital to return his alcohol. Staff had calmed him down and R51 returned to his room. The DON stated no alcohol levels or reports were available from the hospital. There was no record if a physician was contacted for any orders of increased monitoring. The DON confirmed her expectation that increased monitoring would be completed as well as an incident report. The DON also stated R54 had posted a note on his door stating he was not to be disturbed unless it was for the gazebo. The SSD stated R51 had to eat lunch, or he would not be able to attend the gazebo program and added, "He is taking it more serious lately because it is important to him." - On 12/5/15, at 1:47 p.m. documentation indicated R51 had not been allowed to attend the Gazebo for breaking rules yesterday [12/4/15] (drinking alcohol outside the Gazebo program). - On 12/5/15, at 6:49 p.m. notes indicated R51 had not been allowed to attend the Gazebo program until re-evaluated after the weekend.	F 250		

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F 250	Continued From page 22 When interviewed on 5/11/16, at 3:02 p.m. the SSD stated at that time R51 had been restricted from the Gazebo program for one day, which she verified did not correlate with the Gazebo Alcohol Program Contract which directed a one week violation for drinking outside of the gazebo program. A Psychology Progress Note dated 2/16/16, identified R51 had been treated for depressed mood and alcohol use disorder. "Patient is now want [sic?] to control drinking program. He has not had any acute binge episodes that I am aware of recently." Previous visit with psychology was dated 11/17/15. - On 1/10/16, at 1:44 p.m. notes indicated R51 quickly returned from the Gazebo program after receiving ice from staff. There was a covered coffee cup noted behind the resident. R51 was asked if staff could check the cup, and after R51 stated "yes" it was noted to smell of alcohol. The cup was taken, and the resident chased staff around the front lobby. The note indicated the SSD had been notified and R51 was restricted from the Gazebo the following day for breaking rules. The record lacked evidence the Gazebo policy was followed, which directed a one week violation for drinking outside of the Gazebo program. - On 2/3/16, at 4:53 p.m. R51's quarterly note identified when he participated in programs after the gazebo program, he was noted to be talking inappropriately/making sexual comments. - On 2/29/16, at 7:32 a.m. R51 refused to have a Keppra level drawn, and became verbally	F 250		

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F 250	Continued From page 23	F 250		

aggressive with the phlebotomist. The notes indicated R51 had come to nursing station later, stomping his feet and yelling he did not want to be awakened for anything but the Gazebo program.

On 5/11/16, at 3:02 p.m. the SSD stated R51 had a history of only wanting to be awakened for the Gazebo program, stating he'd been informed he needed to eat lunch before attending the program, and had been compliant with this. The SSD stated there had been no restriction from the gazebo program for refusing therapy/services, or from behaviors of yelling at staff when they enter his room to offer services.

- On 3/13/16, 12:19 p.m. notes indicated R51 had been yelling at staff in his room for waking him to administer insulin, and had stated the sign on his door indicated to never wake him except for the gazebo program.

- On 3/13/16, at 9:41 p.m. notes indicated R51 had again stated staff should only wake him for the Gazebo program.

- On 3/14/16, at 2:49 a.m. resident was noted to be offered insulin prior to lunch. The notes indicated R51 had stated, "NO...DO NOT EVER WAKE ME...ONLY WAKE ME FOR GAZEBO."

- On 3/31/16, at 5:45 p.m. Therapy discontinued for gait training due to resident either refusing or attempting to be seen after the gazebo program.

- On 4/12/16, at 3:00 a.m. R51 was informed of an emergent call from his son. R51 stated "I do not care if it is an emergency. I only want to be woke up for GAZEBO."

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F 250	Continued From page 24 - On 5/6/16, at 8:55 p.m. R51 requested to never be awakened for anything but the Gazebo. On 5/13/16, at 10:44 a.m. R51 was interviewed and stated he had been at the facility for about a year and a half, and had been part of the Gazebo program ever since. He said he'd agreed to come to this nursing home "because I was able to drink and smoke." R51 stated he signed a contract for the program, but was not exactly sure what it specified. "I didn't read it thoroughly. I had to sign to participate." Further, R51 stated the alcohol was purchased by the SSD, and it was locked up. "I have been restricted on one or two occasions, when I drank more than I should have." R51 stated when he was hospitalized, he had only been restricted for 1-2 days. "I don't drink on outings anymore. I have nobody locally to take me on outings. I would if I could." The facility knows if I go out "I am probably gonna drink. I'm not driving." When interviewed about the facility's Gazebo program on 5/11/16, at 4:05 p.m., the SSD stated residents need to ask to be on this, and are then evaluated by the interdisciplinary team (IDT). The SSD said she evaluates whether the resident is appropriate behaviorally to be on the Gazebo program, and then nursing and the physician evaluate if they are appropriate medically. The SSD stated, "if a resident drinks outside the gazebo program, the policy spells out the consequences", and that her hope was that the policy would be followed. The facility's undated policy Alcohol and Drug Use, identified: "Purpose: A primary mission of	F 250		

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F 250	Continued From page 25 Mission Nursing Home is to provide care to residents who are chronically chemically dependent. While encouraging and supporting the efforts of residents to maintain sobriety, the facility also recognizes that some persons will relapse or continue to use alcohol and drugs. This policy is adopted to provide guidelines on the use of alcohol and drugs, with the goals of a safe and healthy environment in mind, while also supporting and encouraging sobriety." In addition the policy included: 1. Mission Nursing Home will support any and all efforts at sobriety and is available to give you assistance at all times. 2. In order to participate in the Gazebo program, the resident will be assessed by therapy, nursing, and the behavior management committee. 3. The use or possession of alcohol in the building is not permitted. Random room searches are conducted to ensure there is no alcohol in the building. 4. Inappropriate behavior resulting from the use of alcohol will not be allowed and will be addressed according to the facility behavior management policy. An undated facility policy titled Behavior Policy, indicated "violent, criminal or inappropriate sexual behavior in public will not be tolerated by Mission Nursing Home. Residents who engage in such behavior in public will be discharged from the facility." Examples of such behavior included assault (including threats of assault). The policy also identified other inappropriate behavior in affecting the health, safety, or welfare of the resident and/or the community would not be allowed. "Residents who engage in such behavior in public and who repeat the behavior twice will be discharged from the facility." Examples of	F 250		

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F 250	Continued From page 26 such behavior included self-endangerment.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R66) was comprehensively assessed for Level II	F 278	It is Mission's policy that each resident will have an assessment completed that accurately reflects the resident's status. To assure compliance the following plan has been implemented: 1.R66's MDS was modified with correct information. 2.DSS will develop and keep a list of all residents with Level II PASRR. 3. All current resident MDS's will be reviewed for Level II PASRR accuracy by nurse managers. 4. Nurse Managers will audit all new admissions with Level II until compliance is determined by the QA committee. All audit outcomes and modifications to current residents will be reviewed by the QA committee for continued compliance for three (3) months. Responsible: Nurse Managers/DON	8/1/2016

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F 278	Continued From page 27 Preadmission Screening and Resident Review. Findings include: R66's admission Minimum Data Set (MDS) dated 3/10/16, incorrectly identified R66's requirement for a Level II Preadmission Screening and Resident Review (PASRR) for residents with a mental illness, mental retardation or related illness. The MDS indicated that R66 had not been assessed for a Level II PASRR, and the MDS should have indicated the resident had been screened for a Level II PASRR. R66's Evaluative Report Level II Preadmission Screening for Persons with Mental Retardation or Related Conditions indicated R66 was evaluated on 8/8/14. R66's proposed date of admission to the facility was 2/3/11. The Level II PASRR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASRR further indicated " This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." When interviewed on 5/13/16, at 10:27 a.m. the director of nursing (DON) stated that it appeared there was an error in documentation, on the MDS and it should have been documented as yes. The DON further stated that individualized services were not provided according to the the Level II PASRR as the facility did not have the individualized service plan (ISP) from the county agency. If the MDS had been coded correctly the county could have been contacted for the ISP, so	F 278		

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F 278	Continued From page 28 the facility could provide the needed services.	F 278		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide daily assistance with shaving for 1 of 3 residents (R 38) who required assistance with activities of daily living. Findings include: R38 was admitted to the facility on 5/21/15. R38's quarterly Minimum Data Set (MDS) dated 2/16/16, identified R35 had moderate cognitive impairment. Further more, R38's MDS identified him as having Alzheimer's disease, receiving hospice care, and requiring extensive physical assistance with personal hygiene. R38's care plan dated 4/26/16, identified him as having a self care deficit in ADL's requiring one staff to assist with grooming. R38's care plan further specified for staff to "Encourage to wash his face and hands." The care plan did not specify any preferences in the cares provided with grooming. R38's face sheet included an admission photo in	F 312	It i s the policy of Mission NH to provide for resident's who are unable to carry out activities of daily living with the necessary services to maintain good nutrition, grooming & personal & oral hygiene. To assure compliance the following plan has been implemented: 1. R38-grooming needs were reassessed & care plan & NAR assignment sheet reviewed and updated for accuracy. 2.Mandatory NAR meeting to re-educate on following assignment sheets & plan of care and notifications of changes by 7/29/2016. 3. Nurse Manager or designee will perform scheduled personal care audits to include all residents, by 8/1/2016. 4.Audits will be completed weekly to assure compliance with resident assignment sheets and provide NAR reeducation as needed. 5. Audit outcomes will be reported to QA Committee monthly for three (3) months to assure compliance. Responsible: Nurse Managers	

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F 312	Continued From page 29 which R38 had a thick white and gray mustache. On 5/9/16, at 7:00 p.m. R38 was observed sitting in his wheelchair. White hairs, approximately 1/8" (inch) long, were noted on his upper lip and scattered on both cheeks. On 5/10/16, at 11:33 a.m., R38 was observed with the same white hairs on his upper lip and scattered on both cheeks. The stubble was approximately the same as the day before. On 5/11/16 at 8:24 a.m., family member (F)-A had concerns that R38 was not being shaved often enough. F-A further thought that R38 was only receiving assistance with shaving once a week. F-A stated that shaving was very important to R38, who had been "the most particular person you can imagine" regarding shaving. FA-1 went on to state that shaving "was a huge thing for him." FA-1 stated R38 always kept his mustache in his younger years and would "not feel good" about the mustache being shaved. On 5/11/16, at 7:14 a.m. R38 was again observed sitting in his wheelchair, waiting by a medication cart. R38 continued to have white facial hair on his upper lip and cheeks. The hair on R38's upper lip and cheeks was longer than when observed on 5/9/16. On 5/12/16, at 7:43 a.m. R38 was observed sitting in wheelchair eating breakfast in the dining room. His hair appear wet and had been combed. R38 stated he had had a bath that morning. The white hair on his upper lip and cheeks was now approximately 1/4" long. On 5/13/16, at 10:10 a.m. nursing assistant	F 312		

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F 312	Continued From page 30 (NA)-M stated that R38 received grooming, bathing, and shaving assistance from the hospice aides and the facility nursing assistants. NA-M stated shaving was the responsibility of the facility nursing assistants, not hospice. NA-M stated R38 had his own razor and there was a floor razor for resident use as well. NA-M stated R38 never refused offers to shave and NA-M shaved him that morning. Later that same day at 11:29 a.m. R38 was observed sitting in his wheelchair looking out the window. His face was clean shaven, including the hair on his upper lip. On 5/13/16, at 1:39 a.m., licensed practical nurse (LPN)-B stated R38 was shaved by both hospice and facility staff and went on to state that most residents were shaved every third day. LPN-B stated nursing staff would shave a resident if they needed it because they would "see it [facial hair]." LPN-B further stated residents' care plans identified how often they needed to shaved or groomed. LPN-B verified nursing staff charted shaving with morning cares and documented on cares under the facility document entitled "ADL (activities of daily living) Care Provided." LPN-B explained if the documentation reported shaving had not been done, then R38 was not shaved that day. On 5/16/16, at 10:38 a.m. LPN-A stated shaving was suppose to be a daily event and was included in grooming. LPN-A stated the facility was having trouble finding electric razors at one time and thought some nursing staff did not know how to use non electric razors. LPN-A further stated she would assume nursing staff would know that shaving is part of grooming but has had to remind staff. LPN-A was unaware of where nursing assistants charted grooming cares.	F 312		

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F 312	Continued From page 31 ADL Care Provided sheets were reviewed from 5/11/16 to 5/16/16. Documentation identified that R38 was shaved once on 5/15/16 with extensive assistance. All other documentation under "shaving" between that period of time identified the "activity did not occur." ADL Care Provided care sheets were requested for the previous three months. None were provided. A facility policy entitled Resident Cares Grooming, last reviewed 4/20/06, directed staff to "Assist or supervise each resident with shaving on a daily basis."	F 312		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, and develop safety interventions related to alcohol consumption to reduce the risk of significant harm to residents or others, and to monitor for withdrawal for 3 of 3 residents (R11, R51, R54) who were known to consume alcohol, become intoxicated and who were not being medically monitored. This resulted in an immediate jeopardy (IJ) situation for R11, R51 and R54.	F 323	Mission Nursing Home strives to provide a safe environment for all of our residents to live in. All residents admitted to Mission Nursing Home are considered at risk for potential alcohol abuse. 1 . Develop Alcohol/Substance Use risk assessment with acuity score. Responsible: DSS, DON 2.Alcohol use potential will be care planned and revised quarterly and with significant change at care conferences on all residents. Current residents care plans will also be updated to include individualized alcohol use potential, interventions as determined by the assessment. 3.All residents will have completed assessments by 7/22/2016. Residents with alcohol related incidents over the last six (6) months will be priority. Responsible: Social Workers New assessment tool will be reviewed at next QA committee meeting. Repsonsible: Nurse Managers, DON	7/18/2016 8/5/2016

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F 323	Continued From page 32 Findings include: The immediate jeopardy began on 7/1/15, when R51 had an extremely elevated breathalyzer reading and clinical symptoms without appropriate intervention. During review it was determined R11, R51, and R54 had the potential for significant harm due to multiple incidents of intoxication without intervention by the facility including comprehensive assessment and/or implementation of appropriate interventions based on facility protocols. On 5/12/16, at 3:54 p.m. the facility administrator, director of nursing (DON), and social services director (SSD) were notified of the IJ for R11, R51, and R54. The IJ was removed on 5/17/16, at 2:30 p.m., but noncompliance remained at an isolated scope and severity level, with actual harm that is not immediate jeopardy (Level G). The facility policy Alcohol and Drug Use, undated, identified: "Purpose: A primary mission of Mission Nursing Home is to provide care to residents who are chronically chemically dependent. While encouraging and supporting the efforts of residents to maintain sobriety, the facility also recognizes that some persons will relapse or continue to use alcohol and drugs. This policy is adopted to provide guidelines on the use of alcohol and drugs, with the goals of a safe and healthy environment in mind, while also supporting and encouraging sobriety." In addition the policy included: 1. Mission Nursing Home will support any and all efforts at sobriety and is available to give you assistance at all times. 2. In order to participate in the Gazebo program, the resident will be assessed by therapy, nursing,	F 323	Revise alcohol drug use policy to include consequences of alcohol use on LOA, may include breathalyzing, room searches, person searches, adjusting monitoring level. Refusal to submit to a breathalyzer, in-house alcohol consumption (outside of the Gazebo program) or returning from an LOA intoxicated will trigger a resident's current set of parameters (restrictions) to the next higher level based on their individual circumstances. This will trigger initiation of intoxication impairment protocol. An alcohol related infraction will trigger moving up one or more monitoring levels for one week and then will be re-evaluated by IDT. IDT continues to review all alcohol related incidents each week day. Responsible Director of Social Service (DSS) Quality assurance committee review at next meeting Selected residents (R51, R11, R54) will sign the revised alcohol policy. Current residents will also be signing the updated policy. Responsible: DSS	5/18/2016 8/1/2016

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F 323	Continued From page 33 and the behavior management committee. 3. The use or possession of alcohol in the building is not permitted. Random room searches are conducted to ensure there is no alcohol in the building. 4. Inappropriate behavior resulting from the use of alcohol will not be allowed and will be addressed according to the facility behavior management policy. An undated facility policy titled Behavior Policy, indicated "violent, criminal or inappropriate sexual behavior in public will not be tolerated by Mission Nursing Home. Residents who engage in such behavior in public will be discharged from the facility." Examples of such behavior included assault (including threats of assault). The policy also identified other inappropriate behavior in affecting the health, safety, or welfare of the resident and/or the community would not be allowed. "Residents who engage in such behavior in public and who repeat the behavior twice will be discharged from the facility." Examples of such behavior included self-endangerment. The back side of the policy was titled Informed Consent for Random Search of Room, which residents signed authorizing staff to do random room/surroundings searches whenever there was "reasonable suspicion" of alcohol or drugs present. The policy indicated "Failure to authorize the search can result in immediate discharge planning procedures". The facility's Gazebo Alcohol Program [A program run by the facility, which allows residents to drink a physician approved, set amount of alcohol provided by staff, in a specific area of the building at a specific time each day] Contract, undated,	F 323	Develop individualized resident alcohol related plan of care for R51, R11, R54 (on-going risks of drinking with their diagnosis, praising for policy compliance, breathalyze upon return to facility, search upon every return to the facility). Responsible: DON, Nurse Managers R51: Goal: will comply with MNH alcohol policy through next review. Ensure R51 has no containers in his wheelchair when going down for Gazebo program. Follow Intoxication/Impairment Assessment Tool and protocal indicated as needed. Praise R51 for compliance with alcohol policies. Remind R51 about the rules r/t alcohol in and out of the Gazebo program. Room check random and when suspicion of alcohol possession. Search R51 upon reentry into building. Include looking in socks. When intoxicated encourage R51 to drink water and Gatorade, eat food and rest. Ongoing monitoring for seizure activity d/t history of alcohol withdrawal related seizures.	5/18/2016

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 34 identified in part: 1. Drinking can only be done in the designated area, usually in the barbershop. No drinking is allowed anywhere else in the building or on the grounds. 2. If you drink alcohol in the building, outside of the gazebo program, alcohol is found in your room or on your person, you will be placed on level 4 (cannot go out of the building without an escort) and you will be restricted from the gazebo as follows: First violation = one week Second violation = two weeks Third violation = off program 3. When you receive or buy alcohol give it to the door monitor. 4. Upon return from any outings, you will be searched for alcohol. 5. There may be a search of your room or person if staff suspects that you are hiding alcohol. 9. If you return from an outing, and you have been drinking alcohol, you cannot go to the gazebo that day. 10. If you fall, get into a fight, are belligerent or aggressive, and/or display any other disruptive behaviors after you go to the gazebo and drink alcohol, you will be put on a 3 day restriction from the gazebo program. Multiple offenses will result in increasing restrictions. 11. If you are caught giving or receiving alcohol to each other you will be restricted from the gazebo for 3 days. 12. You will be breathalyzed before participating in the program that day. Refusal to cooperate with breathalyzer will result in restrictions. 13. If you have to go to detox, hospital, or create a dangerous health situation, your level will change to a level 4 (cannot go out of the building	F 323	R11: Goal: R11 will allow Intoxication/ Impairment Assessment Tool when indicated through next review Breathalyzer on any return to facility. Follow Intoxication/Impairment Assessment Tool protocol when alcohol use is known or suspected. Observe for and document any symptoms of alcohol use per Intoxication/Impairment Assessment Tool. Ongoing education regarding risks of continued alcohol consumption on health and safety. Random room search and for suspicion of possession of alcohol. Search for any alcohol upon return to facility. Search to include checking socks. When R11 is intoxicated encourage water or Gatorade intake, food intake and rest.	

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	245546	A. BUILDING _____ B. WING _____	05/17/2016

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F 323	Continued From page 35 without an escort), and will be restricted from the gazebo for two weeks. An undated facility policy, Resident Monitoring System, identified a leveling system for all residents. The purpose of this system was to keep the residents safe and prevent them from behaviors while out in the community. Classification assessments were conducted at admission and annually thereafter unless there was been a change in condition. The levels were reviewed at each quarterly care conference. Classifications were: Level I: A resident can go out without restrictions. Level II: A resident can sign out and walk around the building for up to half an hour. If the resident does not return within half an hour, the door monitor will go out and find them. The resident could be changed to another more restricted level for failing to follow the limitations of this level. Level III: Residents in this category must remain within eyesight of the door monitor (in the front yard). Level IV: Residents in this category must have an escort at all times when outside the facility. Residents who have had significant behavioral issues or significant cognitive deficits are also in this category. Level V: Residents in this category must stay on their individual floor and cannot go to the other floor without escort. A color coded listing of all resident levels was available at the front door, each nursing station, and with each social worker. Per the policy, all residents sign to acknowledge	F 323	R54 is currently discharged to an assisted living facility however until he was discharged the following plan was put into place: R54: Goal: R54 will have no injury r/t alcohol consumption through next review. Check belongings after each outing for alcohol. Check socks as well. Document summary of each episode in progress notes. If impaired indicators are identified, monitor closely for safety by following Intoxication/ Impairment assessment. Ongoing education to R54 regarding the effects and risks of alcohol use with Atrial flutter. Praise R54 for demonstrating alcohol policy compliance. Random room checks for alcohol. Remind R54 and visitors that alcohol may not be brought on the premises Remove any found alcohol and report findings to DON and DSS. When R54 is intoxicated encourage water or Gatorade, food intake and rest.	

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F 323	Continued From page 36 an understanding of all rules related to the use of alcohol/drugs within the facility and when out on pass. This included the use of alcohol and the privileges available when the rules were followed. Review of resident records indicated that although these policies were in place, the provider did not consistently use the leveling system, or have any consistent protocol for use or refusal of the breathalyzer, vital sign monitoring, or frequency and length of clinical and safety monitoring for intoxicated residents. R11's quarterly Minimum Data Set (MDS) dated 3/8/16, identified admission to the facility on 3/1/02. It also identified R11 had modified independence with cognitive skills for daily decision making, and demonstrated feeling down, depressed or hopeless. R11 was noted to be independent with activities of daily living (ADLs). Active diagnoses included diabetes mellitus, non-Alzheimer's dementia, anxiety, depression, cognitive communication deficit, alcoholic cirrhosis of liver, and alcohol dependence. The MDS also identified R11 exhibited other behavioral symptoms not directed toward others, and rejection of care. R11's behavioral symptom Care Area Assessment (CAA) dated 7/2/15, identified R11 had episodes of impaired judgment and poor decision making, noting an episode in which he was in a verbally aggressive altercation with another resident which lead to threatening and physical aggression. "He also has been warned about not going out into the community to drink alcohol or take drugs and/or bring anything back in with him." The CAA documentation lacked any direction or guidance in dealing with these	F 323	Develop Intoxication/Impairment Assessment Tool (to aide in determining intoxication level & appropriate protocol). Responsible- Director of Nursing (DON), Medical Records (MRD) Quality assurance committee review at next meeting. Create policy for using the Intoxication/ Impairment Tool (to aide in determining intoxication level & appropriate protocol). To be done on any resident return from LOA or in-house demonstrating symptoms of impairment. Responsible- DON, DSS, MRD Quality Assurance committee review at next meeting. Medical Director informed of new policy.	5/18/2016

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F 323	Continued From page 37 behaviors. R11's medical record lacked a comprehensive assessment related to safety of alcohol use. R11's medical record lacked a signed Alcohol and Drug Use policy. The face sheet identified R11 as his own responsible party. R11's care plan dated 4/8/16, identified a potential alteration in cognition related to alcohol dependence. It also identified a history of going out 'for a few drinks'. Interventions included: encouraging sobriety, Level I monitoring (date initiated 12/11/11), private room due to inability to get along with roommates, and identifying physical and verbal aggression. The care plan also indicated R11 was at moderate risk for falls due to alcohol or drug use. Interventions included: independent with transfers, and observe orthostatic blood pressure monthly. The care plan lacked specific interventions related to alcohol use. The facility provided a Resident Classification Listing by Room dated 4/18/16. R11 was identified as a Level II (which contradicted information provided on the care plan). On 5/16/16, at 10:01 a.m. the social service director (SSD) was asked about the conflicting level information for R11. The SSD stated she was unsure why R11 was a Level II on the Resident Classification Listing. The SSD stated, [R11] "is a Level I, and has been since 9/23/12. Everyone knows this." R11's Fall/Safety Risks Evaluation and Assessment dated 3/7/16, identified no falls in the	F 323	Revise the Resident Monitoring (Level) Policy to include initial placement at a level IV, individual circumstances may warrant a level change and how staff will be notified of changes. Greater restriction (monitoring) will occur for non-compliance, lesser restrictions (monitoring) for compliance with the program. Responsible: SSD Provide staff education on the revised alcohol policy and the Intoxication/Impairment policy for all staff now, with new hire and yearly Responsible: DON Provide education to the nursing staff on the Intoxication/impairment assessment tool now, with new hire and yearly Responsible: DON, Nurse Managers	5/18/2016

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F 323	Continued From page 38 last 90 days. Additionally, no seizures were noted on the form. The assessment did indicate R11 had a current issue with alcohol and/or drug use, an extensive history of alcoholism, alcoholic cirrhosis of the liver, drunkenness, and alcohol-induced persisting dementia. R11 was identified with no fall risk on this assessment. The assessment indicated "occasionally resident is confrontational with staff and other residents, especially if drinking alcohol." The Medication Administration Record (MAR) for 4/15, identified a physician's order dated 9/26/13, indicating if R11 went out on the evening shift, he was to do a breathalyzer when he returned. If the breathalyzer was refused, he was to be on 15 minute checks. The order lacked a length of time the 15 minute checks were to continue. Review of R11's progress notes dated 4/22/15 through 5/14/16, identified the following: - 5/4/15, at 10:24 p.m. R11 went for a walk at 6:55 p.m., and returned at 9:10 p.m. Refused breathalyzer, stating, "I'm not on the Gazebo program. I don't have to do that anymore." - 5/23/15, at 3:50 a.m. R11 exited his room, agitated, jumping from one subject to another, at times not making sense, talking about drinking in his room. - 5/23/15, at 9:45 a.m. R11 had been speaking to staff in a "foul language". It also noted R11 shared with dietary staff he had been drinking. The documentation included: "In a brief glance around room do not see any alcohol bottles/containers."	F 323	All alcohol related incidences will be reviewed at IDT meeting every week day. Alcohol specific related incidents will be added to the quality assurance agenda (report including: frequency, severity, circumstance, residents having more incidents than others, certain dates, one resident obtaining for others) Will be addressed at the next QA committee (including Medical Director, Pharmacist & Department Managers). Responsible: DSS, Admin Assistant Focused Quality Assurance Meeting scheduled regarding alcohol incidents (policy review) to be held 5/17/2016. Medical Director was forwarded the new policies and protocols prior to meeting for review; and has sent feedback. Responsible: all department managers.	5/18/2016

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F 323	Continued From page 39 - 5/24/15, at 3:30 a.m. identified at 9:50 p.m. R11 was observed blocking the door entrance, with the door monitoring staff outside. R11 began yelling racial slurs to staff and threatening to "physically harm the door monitor." R11 walked toward staff in a threatening manner, swearing, and was informed if he physically harmed staff, the police would be called. R11 went to his room, and returned at 10:05 p.m. cursing, gritting his teeth, and leaning on the nursing station. He was informed the police would be called if he didn't calm down. It was also noted R11's eyes were "extremely blood shot." R11 was checked on x 2 [twice] and appeared to have calmed down. - 6/17/15, at 12:00 p.m. R11 confronted and had a verbal altercation with a peer, and when being escorted out of the dining room, began to threaten the peer, making the motion of a fist, and attempted to get back in the dining room. The note indicated R11 had slurred speech and suspected he had been drinking. R11 stated, "Did he laugh at me, I'm gonna knock the shit out of him." A corresponding incident report dated 6/16/15 was completed, but lacked any additional content. On 5/11/16, at 4:21 p.m. the DON stated she would expect a breathalyzer to have been offered, and if refused, 15 minute checks initiated. - 6/17/15, at 5:55 p.m. the SSD and administrator discussed recent behaviors with R11, and he was informed he could not drink in or out of the building unless in the gazebo program. If he gets intoxicated he has to cooperate with the nurses when they ask for a breathalyzer and if he doesn't comply he will be sent to the hospital and/or the	F 323		

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police will be called to assist. He stated that he understood and certainly did not want the police called due to his behaviors. Finally he was told that he will be given a notice to discharge if there are any more incidents, he responded with "I am leaving soon anyway" and when asked where he was going he could not give an answer. Administrator reiterated everything one final time and he again said that he understood. A couple of hours later he came up to this writer and said if he was given a discharge notice we would have to find a place for him to go and this writer responded yes.

- 6/19/15, at 9:30 a.m. (documented as a late entry) identified R11 was told that he would be given notice to leave if his behaviors continued.

- 7/5/15, at 5:36 p.m. R11 had a verbal altercation with a peer, threatening to "beat each other up." Four staff intervened until the peers walked away from each other.

- 7/7/15, at 7:46 p.m. R11 was in a verbal altercation with a peer, entering peer's room, yelling and cursing at peer.

- 7/10/15, at 3:12 p.m. R11 complained of abdominal pain, and an abdominal x-ray was ordered. R11 stated, "Don't send them in my room, I'll kill them."

-8/20/15, at 1:24 a.m. R11 was complaining about issues to staff. He then began cursing and became agitated.
- 9/4/15, at 4:32 p.m. staff reported to nurse R11 appeared to be drunk. The SSD and administrator entered R11's room with the breathalyzer. When asked if he had been drinking

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F 323	Continued From page 41 last night or this morning, R11 denied it. His speech was somewhat slurred. Breathalyzer read 0.204, and a retest of the breathalyzer was 0.203. "This writer and Administrator then reminded him of a discussion in which he stated that he understood that if an incident like this happened again he would be given a notice to leave. He said that he remembered this. This writer then informed him that a referral would be made for the Glennwood, (wethouse) [a residential facility for chronically alcoholic and homeless men and women], so that discharge planning could begin. He stated understanding of this." On 5/11/16, at 4:21 p.m. the DON stated she would expect 15 minute checks to be completed for refusal of the breathalyzer, and an incident report to be completed. On 5/17/16, at 12:50 p.m. SSD stated R11 was referred to the Glennwood, but he was not accepted there, due to having a colostomy (surgical procedure that brings one end of the large intestine out through the abdominal wall), despite the fact that R11 is independent in the cares for this. The reason provided was that residents share a bathroom. - 9/8/15, at 10:22 p.m. R11 was found on the floor near the door in his room. He appeared drunk but refused breathalyzer and vital sign assessment. Resident stated "don't call the police I am already in trouble." Corresponding incident report completed, identified plan to "possibly" give resident a 30 day notice to discharge. On 5/11/16, at 4:21 p.m. the DON verified no documentation was available related to 15 minute checks for refusal of the breathalyzer.	F 323		

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F 323	Continued From page 42 - 9/9/15, at 5:44 p.m. Staff reported R11 appeared drunk. SSD and another staff entered R11's room. R11 refused breathalyzer. He was informed if he did not do the breathalyzer, "it was the same as saying that he had been drinking." R11 continued to refuse, and closed his eyes. - 10/19/15, at 6:15 p.m. R11 left facility at 8:30 p.m. and returned at 9:50 p.m. Breathalyzer read 0.105. - 10/23/15, at 10:19 p.m. R11 went out from 5:45 p.m. - 9:35 pm. Breathalyzer read 0.162. - 10/31/15 at 7:15 p.m. R11 had a verbal altercation with housekeeping. A corresponding incident report completed on 10/31/15 lacked any further information. - 11/7/15, at 7:27 p.m. R11 went out at 6:50 p.m., returning at 7:11 p.m. Breathalyzer read 0.022. - 11/9/15, at 9:45 p.m. R11 left at 8:00 p.m., and returned at 8:50 p.m. Breathalyzer read 0.077. - 11/16/15, at 12:30 a.m. R11 to the nurses station asking for medication he had previously refused. He became "very upset and began cursing". Staff attempted to talk with R11, but he refused to listen and walked off to his room. - 11/16/15, at 6:30 p.m. R11 out of the building from 6:30 p.m. - 8:30 p.m. Breathalyzer was 0.08. On 5/11/16, at 4:21 p.m. the DON stated an incident report should have been completed, as well as 15 minute checks.	F 323		

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F 323	Continued From page 43 - 11/19/15, at 10:54 p.m. R11 out of the building and breathalyzer read 0.06 upon return. When interviewed on 5/11/16, at 4:21 p.m. the DON stated breathalyzer was below the legal limit, and she wouldn't expect any increased monitoring. The DON stated she was not notified, and would expect herself or the SSD to have been notified of any incident involving drinking of any amount, and would expect an incident report completed. - 12/24/15, at 5:30 p.m. R11 was found with two cans of beer in his room, observed to be dumping it down the drain when staff entered. R11 began cursing, slammed the cabinet door shut with his foot. On 5/11/16, at 4:21 p.m. the DON stated no breathalyzer was done. The DON also stated a room search revealed no further alcohol, and she was notified of this incident. There were no further symptoms, and she would not expect 15 minute checks. Further, the DON stated R11 was aggressive, but he was also aggressive without alcohol. - 3/29/16, at 9:13 p.m. R11 left the facility at 6:20 p.m. and returned at 9:20 p.m. R11 reported being down by the lake, and breathalyzer reading was 0.143. - 4/13/16, at 9:06 p.m. R11 left the building and refused breathalyzer upon return. - 5/7/16, at 6:40 p.m. R11 left the facility at 2:05 p.m. and returned at 6:39 p.m. Breathalyzer read 0.256. Resident went to his room.	F 323		

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F 323	Continued From page 44 When interviewed on 5/11/16, at 4:21 p.m. the director of nursing (DON) stated incident reports should have been completed, as well as enhanced monitoring when there was a refusal of the breathalyzer. The DON stated there was no protocol for enhanced or increased monitoring. However, the DON stated R11 should have been on 15 minute checks for refusal of the breathalyzer per his physician order. On 5/11/16, at 4:21 p.m. the SSD stated R11 was not on the Gazebo program because he didn't want to follow the rules, and it was his right to drink. The DON also verified that on 5/7/16 when R11's breathalyzer reading was so high, R11 had gone to his room. The DON was unable to provide any documented assessment at that time such as vital sign readings, or increased clinical and safety monitoring having been done. The DON stated she would have expected an incident report and 15 minute checks to have been completed. R11's Social Services Review notes dated 3/10/16, identified "He does display some short term memory deficits some of which could be selective memory. He has episodes of impaired judgement." The notes also included, "He can also be verbally aggressive towards staff especially when they want him to do something. He does not want anyone in his room even after knocking. He has episodes of drinking inside or outside of the building and then denying that he has. Social Service will remain actively involved through 1 to 1 visits and behavior management interventions as needed." During observations on 5/11/16, at 2:25 p.m., 5/13/16, at 10:41 a.m., 5/15/16, at 11:44 a.m.,	F 323		

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F 323	Continued From page 45 5/16/16, at 1:10 p.m., and 5/16/16, at 3:00 p.m., R11 was asleep in bed, and did not reply when spoken to. On 5/11/16, at 6:55 a.m. the DON reiterated that if a resident returned intoxicated, she would expect a nursing assessment to be completed, and with a breathalyzer reading of 0.256, she would expect increased monitoring to be done. She also stated R11 had a history of coming back to the facility intoxicated, but was unable to find any documentation of increased monitoring done for any of the incidents when R11 returned with signs and symptoms of intoxication and refused a breathalyzer. R51's quarterly MDS dated 4/28/16, identified the resident had modified independence in cognitive skills for daily decision making, behavioral symptoms not directed toward others, and required the use of a wheelchair. Diagnoses included hypertension, diabetes mellitus, seizure disorder/epilepsy, and depression. R51's CAA dated 11/3/15, identified diagnoses of acute alcohol intoxication/withdrawal, physical weakness, depression, limited range of motion, poor coordination, poor balance, and visual impairment. It also identified behavior problems including disruptive, loud talking in the dining room "especially after Gazebo/alcohol program." The CAA noted impaired balance during transitions, and difficulty maintaining sitting balance as well as agitation and decreased mobility. The CAA lacked any direction or guidance in dealing with these behaviors. R51 did not have a comprehensive assessment related to the safe use of alcohol.	F 323		

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F 323	Continued From page 46 R51's medical record included a signed contract to participate in the Gazebo program dated 8/7/15. However, there was not a signed Alcohol and Drug Use policy. The face sheet identified R51 as his own responsible party. R51's care plan dated 4/27/16, identified a self care performance deficit related to alcohol use. It also identified R51 had a potential risk for falls related to being wheelchair bound, and the use of alcohol with the Gazebo program. The plan of care indicated both long and short term memory problems, and poor judgement and decision making due to alcohol dependence. The care plan also identified an alteration in mood and behavior related to acute alcohol intoxication/withdrawal. Interventions included to remind of the rules around the gazebo/ alcohol program. The care plan failed to identify R51's alcohol monitoring level. The Resident Classification Listing By Room form, dated 4/18/16, identified R51 as a Level III. Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following: A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility." - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo program. "Client monitored closely". Blood pressure upon waking is 75/54 and heart rate 75. Given meal tray and drank 300 ml (milliliters) of	F 323		

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F 323	Continued From page 47	F 323		

water. Blood pressure at 6:30 p.m. 87/53. Physician notified and orders received to check blood pressure every four hours and continue to encourage fluids. Other notes from this date identified resident left at 10:35 a.m. with his niece and returned at 1:05 p.m. He was searched and breathalyzer was 0.258. Staff found a bottle of whiskey in his room, which was locked in the liquor cabinet. An incident report was completed for this incident on 7/1/15, noting "Resident was instructed to not drink." The record lacked evidence their Gazebo policy was followed.

On 5/11/16, at 3:02 p.m. the SSD stated, "if they mess up like this when in the program, they would be suspended for 3 days, or a week if they are sent to the hospital or detox."

- On 7/2/15, at 10:48 a.m. a note indicated R51 had been seen by the nurse practitioner, and the note indicated R51 is an adult and can drink and smoke when he wants. "He is not hurting himself or anyone else."

- On 7/2/15, at 1:59 p.m. a note identified R51 was on a three day suspension from the Gazebo program.

A Physician Progress note for R51 dated 7/2/15, identified the chief complaint as alcohol intoxication. It noted resident had a breathalyzer reading of 0.258, and blood pressure was noted to be low at 87/56, with a retake at 75/54. The note indicated during interview with the physician the resident had stated, "I am fine, I went out with someone and had some drinks. I am an adult and I will do whatever I want. I am here because I can drink and smoke. If I get the opportunity again, I will do it. I am not hurting myself or anyone else

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F 323	Continued From page 48 when I drink, so I should be left alone." The nursing progress notes indicated R51 was allowed to sleep it off, there was no report of aggressive behavior towards staff and included, "Patient will be off Gazebo program for three days. Nursing will continue to monitor for any sign of withdrawal." - On 7/8/15, at 1:20 p.m. the notes indicated R51 was restricted from the gazebo program due to having the bottle. - On 8/6/15, at 10:11 p.m. notes indicated the resident had left with his niece at 2:15 p.m. and returned at 3:45 p.m., appearing drunk and very talkative. "Social worker notified, and resident will be monitored." It was also documented R51 had refused the breathalyzer as well as other assessments. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m. the DON stated enhanced monitoring should have been completed as well as an incident report for these incidents. - 8/17/15, at 3:51 p.m. resident left after the Gazebo program in a taxi at approximately 3:13 p.m., attempting to take a peer with him. The documentation indicated the SSD had attempted to stop the resident, but he'd left anyway and had returned at approximately 3:46 p.m. with a brown paper bag, and a bottle of alcohol in it. The notes indicated staff had taken the bag, and the resident was verbally abusive toward staff. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m. the DON stated the	F 323		

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F 323	Continued From page 49 alcohol was taken from R54 and locked up in a cabinet. A Code B (a behavior that cannot be controlled, where all available staff come to help) was called since R54 was following the staff and threatening her. When the nurse went in, R54 was intoxicated, slurring his words. Breathalyzer at this time was 0.336, and his blood pressure was running low. The on call physician was called, and instructed staff to monitor resident, encourage fluids, and to call back if there was a decline. DON stated the blood pressure was stable later. Further, DON stated there is not policy or procedure to follow and the physician does not specify a frequency of the checks. - On 8/17/15, at 11:10 p.m. noted resident was examined by a registered nurse in his room at approximately 7:25 p.m. He was "clearly intoxicated, fatigued, and slurring his words." Breathalyzer was 0.336. Blood pressure 94/59 and 86/54. Physician notified and orders received to monitor resident and encourage fluids. Call back with a decline. At 10:00 p.m. blood pressure was 146/82. Also noted at this time to be more awake, not slurring words, and drinking fluids. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m., the DON stated the only documentation of checks was in the note from the nurse which indicated R54 was checked on every 1-2 hours. She would expect that an incident report and increased monitoring were completed. - On 8/18/15, at 2:57 a.m. noted at approximately 12:15 a.m. staff attempted to obtain vital signs, and resident was increasingly agitated, using foul language. Noted staff obtaining frequent checks on resident every one to two hours for safety.	F 323		

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F 323	Continued From page 50 A Physician Progress Note dated 8/21/15, identified a review of the incident [dated 8/17/15] where resident returned to the facility and had a breathalyzer of 0.33. The note indicated the vital signs were now normal and resident is back to his baseline. During interview with the physician, R51 stated he was "angry that the social worker can not allow him to bring his own 'Booze' into the facility. He was also angry that he will be off the Gazebo program for 3 days since he got himself intoxicated." The progress note identified no education and no orders were provided for increased monitoring when R51 was intoxicated. Then note indicated nursing was to continue to monitor for any signs or symptoms of withdrawal. - On 9/28/15, at 10:36 p.m. resident returned to the facility via taxi at approximately 6:00 p.m. and was met at the door by SSD. He turned in his alcohol bottles, and breathalyzer was 0.141. Resident was informed by SSD that he will not be attending Gazebo tomorrow. On 5/11/16, at 3:02 p.m., the SSD stated R51 liked to go out and drink with his meals. She verified the Gazebo policy identified that drinking outside the program would result in a one week suspension, which had not been enforced in this case. At that time, the DON also stated, "we are assuming that he is going to go out and drinking." The DON stated there was no assessment available to use for residents consuming alcohol. She indicated an incident report and increased monitoring should have been initiated. - On 10/24/15, at 1:33 p.m. notes indicated R51 had refused to shower the evening before, and had been informed he could not attend the	F 323		

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F 323	Continued From page 51 Gazebo program, so had become very upset and angry. - On 11/5/15, at 11:24 p.m. identified R51 had returned at 5:35 p.m. from going out on a visit with his brother [left at 12:05 p.m.] The note indicated he was drunk and went to his room after being searched. The record lacked evidence the Gazebo policy having been implemented. On 5/11/16, at 3:02 p.m. the DON stated an incident report should have been completed, a breathalyzer offered, and enhanced monitoring completed. At that time the SSD also stated there should have been a restriction for not following the gazebo contract. - On 12/4/15, at 10:26 p.m. the notes indicated R51 had gone out at 12:05 p.m. At approximately 6:00 p.m. a call had been received about the resident being drunk at a local liquor store, and being under supervision of the police. R51 had been sent to the hospital. The hospital visit note dated 12/4/15, indicated R51 had arrived via ambulance. "Report that patient was outside a liquor store in Plymouth with intoxication. Police were called. Arrives with appearance of intoxication and slurring words. Patient is wheelchair bound. Reportedly lives at Mission detox center." Further information included, "Patient was conversing in room when he had loss of consciousness on the cart lasting about 30 seconds. Patient unresponsive to sternal rub. Came to after 30 seconds and started yelling incoherently." The last note from this visit identified "Pt [patient] increasing agitation; numerous requests for his belongings and to be allowed to leave. MD [physician] in room speaking with pt."	F 323		

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F 323	Continued From page 52 On 5/11/16, at 3:02 p.m. the DON stated dispatch had called the facility regarding the 12/4/15 incident. The SSD also stated R51 had gone out to eat, and the restaurant was across from a liquor store. The SSD stated R51 had left the restaurant and gone to the liquor store. Staff at the liquor store had subsequently called the police, reporting someone intoxicated. The SSD stated the facility did not have a copy of the police report. The DON stated she'd instructed dispatch to take R51 to the hospital for evaluation. Upon return to the facility after six hours, R51 had refused the breathalyzer or vital signs. The DON said R51 had been demanding staff call the police and hospital to return his alcohol. Staff had calmed him down and R51 returned to his room. The DON stated no alcohol levels or reports were available from the hospital. There was no record if a physician was contacted for any orders of increased monitoring. The DON confirmed her expectation that increased monitoring would be completed as well as an incident report. The DON also stated R54 had posted a note on his door stating he was not to be disturbed unless it was for the gazebo. The SSD stated R51 had to eat lunch, orhe would not be able to attend the gazebo program and added, "He is taking it more serious lately because it is important to him." - On 12/5/15, at 1:47 p.m. documentation indicated R51 had not been allowed to attend the Gazebo for breaking rules yesterday [12/4/15] (drinking alcohol outside the Gazebo program). - On 12/5/15, at 6:49 p.m. notes indicated R51 had not been allowed to attend the Gazebo program until re-evaluated after the weekend.	F 323		

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F 323	Continued From page 53 When interviewed on 5/11/16, at 3:02 p.m. the DON stated an incident report should have been completed, as well as increased monitoring. The SSD also stated at that time that R51 had been restricted from the Gazebo program for one day, which she verified did not correlate with the Gazebo Alcohol Program Contract which directed a one week violation for drinking outside of the gazebo program. A Psychology Progress Note dated 2/16/16, identified R51 had been treated for depressed mood and alcohol use disorder. "Patient is now want [sic?] to control drinking program. He has not had any acute binge episodes that I am aware of recently." Previous visit with psychology was dated 11/17/15. - On 1/10/16, at 1:44 p.m. notes indicated R51 quickly returned from the Gazebo program after receiving ice from staff. There was a covered coffee cup noted behind the resident. R51 was asked if staff could check the cup, and after R51 stated "yes" it was noted to smell of alcohol. The cup was taken, and the resident chased staff around the front lobby. The note indicated the SSD had been notified and R51 was restricted from the Gazebo the following day for breaking rules. The record lacked evidence the Gazebo policy was followed, which directed a one week violation for drinking outside of the Gazebo program. - On 2/3/16, at 4:53 p.m. R51's quarterly note identified when he participated in programs after the gazebo program, he was noted to be talking inappropriately/making sexual comments. - On 2/29/16, at 7:32 a.m. R51 refused to have a	F 323		

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F 323	Continued From page 54 Keppra level drawn, and became verbally aggressive with the phlebotomist. The notes indicated R51 had come to nursing station later, stomping his feet and yelling he did not want to be awakened for anything but the Gazebo program. A Physician note dated 4/12/16, indicated, "Patient taking Keppra, refused keppra level draw on request. Nursing will attempt again to draw keppra level next lab day. No report of seizures since admission to the facility." On 5/11/16, at 3:02 p.m. the SSD stated R51 had a history of only wanting to be awakened for the Gazebo program, stating he'd been informed he needed to eat lunch before attending the program, and had been compliant with this. The SSD stated there had been no restriction from the gazebo program for refusing therapy/services, or from behaviors of yelling at staff when they enter his room to offer services. - On 3/13/16, 12:19 p.m. notes indicated R51 had been yelling at staff in his room for waking him to administer insulin, and had stated the sign on his door indicated to never wake him except for the gazebo program. - On 3/13/16, at 9:41 p.m. notes indicated R51 had again stated staff should only wake him for the Gazebo program. - On 3/14/16, at 2:49 a.m. resident was noted to be offered insulin prior to lunch. The notes indicated R51 had stated, "NO...DO NOT EVER WAKE ME...ONLY WAKE ME FOR GAZEBO." A physician's note dated 4/12/16, identified	F 323		

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F 323	Continued From page 55 "Random blood glucose high from 112 to 298 since beginning of February till date, has been higher in the 300s in the past months. HgbA1c (a blood test that provides information about a person ' s average levels of blood glucose, also called blood sugar, over the past 3 months) high at 9.4 as at 1/11/16, was 7.7 in October 2015. Has gone 2 point higher than before." The note also indicated, "Patient was started on Latus [sik] in Feb [February] 2016, random blood glucose ranging from 132-180 since the beginning of April. No report of hypoglycemia, seizure from nursing. Patient reported to be refusing blood draws and finger sticks at times." - On 3/31/16, at 5:45 p.m. Therapy discontinued for gait training due to resident either refusing or attempting to be seen after the gazebo program. - On 4/12/16, at 3:00 a.m. R51 was informed of an emergent call from his son. R51 stated "I do not care if it is an emergency. I only want to be woke up for GAZEBO." - On 5/6/16, at 8:55 p.m. R51 requested to never be awakened for anything but the Gazebo. On 5/10/16, at 12:17 p.m. the DON stated no assessments had been completed on residents related to alcohol use unless they are a part of the gazebo program. The DON stated, "Residents cannot drink at the facility unless they are a part of this program, and should not be going out and drinking. If they come back intoxicated, staff are expected to ask if a breathalyzer can be performed. If this is refused, nursing should be checking vital signs, and monitor them through the night. If the resident is a danger and not medically stable, they should be	F 323		

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F 323	Continued From page 56 sent to detox. The physician should be notified of anyone drinking." The DON stated there was no specific policy about when results of the breathalyzer level should be reported to the physician but stated, "If a person is on the gazebo program and goes out drinking, they are off the program for a specific amount of time. After that, the SSD and administrator handle the resident, since they are in violation of the policies at the facility." The DON also stated she would expect that all incidents involving alcohol and breathalyzers be reported to her. On 5/13/16, at 10:44 a.m. R51 stated he had been at the facility for about a year and a half, and had been part of the Gazebo program ever since. He agreed to come to this nursing home "because I was able to drink and smoke." R51 stated he signed a contract for the program, but was not exactly sure what it specified. "I didn't read it thoroughly. I had to sign to participate." Further, R51 stated the alcohol was purchased by the SSD, and it was locked up. "I have been restricted on one or two occasions, when I drank more than I should have." R51 stated when he was hospitalized, he had only been restricted for 1-2 days. "I don't drink on outings anymore. I have nobody locally to take me on outings. I would if I could." The facility knows if I go out "I am probably gonna drink. I'm not driving." When interviewed on 5/17/16, at 8:26 a.m. the consultant registered pharmacist (RP) stated it would not be recommended to use alcohol while taking Keppra, due to the sedation and the side effect of sedation when alcohol and Keppra were used together. The MD had addressed the need for the medication. The RP also stated the facility had not informed her of the alcohol use by the	F 323		

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F 323	Continued From page 57 residents, except that R51 was in the Gazebo program. R54's annual MDS dated 12/19/15, identified medical diagnoses which included a seizure disorder and depression, with no memory impairment. R54's Social Services Review dated 12/14/15, indicated R54 had a history of significantly impaired judgement secondary to alcohol dependence. The review identified R54 had no alcohol related problems and had not displayed any significant behaviors. The review included social services would continue with active interventions including 1:1 visits and discharge planning as needed. R54's CAA for psychotropic drugs dated 12/19/15, identified R54 received Keppra (medication to control seizures) daily for a history of seizures, which were alcohol induced and currently there was no alcohol use. R54's quarterly MDS dated 3/10/16, identified R54 made poor decisions and cues and/or supervision was required. The MDS identified R54 had verbal and other behaviors, however failed to address if the behaviors put himself or others at risk for injury. The MDS also identified R54 was independent with activities of daily living (ADL's) and had one fall without injury since admission. R54's medical record lacked a comprehensive assessment related alcohol use. R54's care plan dated 3/16/16, identified R54 was at high risk for falls related to alcohol use and had	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 58 a history of falls prior to admission as well as a fall on 3/3/16, related to suspected drinking. Interventions included staff to observe the whereabouts and safety of the resident when he is sitting outside. The care plan also addressed R54's alcohol abuse and that R54 will go out and may drink which could alter his ability with ADL's. The interventions listed did not address what staff should do if his ADL's were altered do to drinking. The care plan also addressed R54 was independent in bed mobility, transfers and ambulation with a four wheeled walker throughout the facility and outside. Interventions included R54 to be independent with ambulation with the walker throughout the facility and outside. The care plan dated 4/8/16, identified an alteration in behavior and mood with episodes of drinking either at the facility or outside the facility and then denying he did it, with refusals to comply with discharge planning. Interventions listed included 1:1 visits to discuss concerns and develop positive solutions and refer to psychologist as needed for mood concerns. The care plan failed to identify safety interventions for R54. R54's nurse practitioner (NP) note dated 3/4/16, identified R54 had lifelong/ current alcohol abuse, and noted R54 denied he will drink any longer. Staff to monitor. R54's medical record lacked any daily tracking for behaviors and/ or alcohol use. R54's NP note dated 4/11/16, identified staff smelled alcohol after patient returned from outings, and that he left in a cab daily. The note also identified that R54 had falls without injury and had refused breathalyzer testing. The NP indicated he was receiving a 30 day notice soon	F 323		

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	245546	A. BUILDING _____ B. WING _____	05/17/2016

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F 323	Continued From page 59 and noted, that due to his chronic alcoholism it may be necessary to find him housing where drinking is allowed and monitored. R54's medical record lacked a signed Alcohol and Drug Use policy R54's Order Summary Report, last reviewed on 5/9/16, included diagnoses of alcohol dependence and major depressive disorder. The undated nursing assistant sheet, directed staff to observe for drinking and alert the nurse if there was alcohol on R54's breath. The Resident Classification Listing By Room dated 4/18/16, indicated R54 was a Level 1 and needed to be searched upon return to the facility. The information was not included on R54's care plan. A progress note dated 12/13/16, identified R54 had a history of alcohol abuse. A progress note dated 2/10/16, indicated a staff member reported that she thought R54 had been drinking. R54 denied he had been drinking. A search of his room was conducted and no alcohol was found. A breathalyzer was administered and the the resident's reading was 0.177. R54 was informed that since he was not acting drunk or having behaviors he would not need to go to detox this time. The documentation lacked any monitoring or follow up of R54's condition. On 5/11/16, at 3:52 p.m. the SSD stated R54 was at the facility short term doing therapy, and staff "don't want him to drink. He is another one that when he says he goes out will drink." The SSD	F 323		

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F 323	Continued From page 60 stated bags were to be searched upon his return. Further, SSD stated they are working on finding R54 an alternate placement, and the insurance company was working with him on this. The DON stated R54 fell when he drinks, and has a significant alcohol use history. The DON also stated it would not be advised for R54 to drink while taking Keppra. The DON stated no documentation was available on increased monitoring and no incident report had been completed. The facility's incident log identified R54 had the following alcohol related incidents: - 3/3/16, at 11:15 p.m. R54 was found on the floor by the entryway to the room and a alcohol bottle was found. On 5/11/16, at 3:52 p.m. the DON stated no breathalyzer was completed. Vital signs were checked with the neuro assessment. "He is at risk for falls when he is drinking." R54 sustained a skin tear on his right elbow from the fall. - 4/8/16, at 9:49 p.m. R54 fell in his room. Resident smelled like he had been drinking alcohol, denies drinking and refused to do breathalyzer. DON notified. Three full Gatorade bottles at bedside. Vital sign checks done with the neurological assessment. On 5/11/16, at 3:52 p.m. the DON stated increased monitoring was completed. The SSD stated if a 30 day notice was provided, the administrator would be informed and the interdisciplinary team (IDT) would discuss it. She also stated R54 was "hooked up with the Medicare coordinator. The county does the	F 323		

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F 323	Continued From page 61 relocation thing and they help him look at places." The SSD stated she talked with the county and discussed placement options, and stated "I believe his last day is the 14th [5/14/16]". - 4/11/16, at 7:50 p.m. R54 fell in room trying to go to bed, smelled of alcohol. - 4/23/16, at 3:45 p.m. R54 found on the floor and smelled of alcohol. On 5/11/16, at 3:52 p.m. the DON stated she would expect staff to call the physician, do an incident report, and notify the administrator. R54 was considered a high fall risk when he was drinking. The SSD stated "We have AA (alcoholics anonymous) that comes here, but these guys are not going to do that." R54's Comprehensive Fall Report Form dated 3/3/16, identified R54 was found on the floor on his back in the entry area of his room. The form identified R54 smelled of alcohol and an empty bottle of vodka was found on the floor. R54 was unable to do a breathalyzer as the resident could not blow into the device correctly. R54 sustained a 1/2 centimeter abrasion to his right elbow. R54's blood pressure was 98/50 with a pulse of 79, neuro checks were initiated due to an unwitnessed fall. Immediate interventions included increased level of observation, call light in reach and no more alcohol tonight. The investigation section identified that R54 appeared to have been consuming alcohol. The final analysis and plan included re-education on the alcohol policy of the facility. The corresponding IDT Review progress note dated 3/7/16, indicated R54 was re- educated on alcohol policies. No other interventions were identified to assist with	F 323		

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F 323	Continued From page 62 ensuring R54's safety with the use of alcohol. R54's Social Service Review dated 3/11/16, indicated R54 had some short term memory deficits, especially after drinking along with some episodes of impaired judgement. The review also identified throughout the quarter R54 had episodes of drinking either out of the facility and coming back or "somehow" was sneaking it back into the facility and drinking in his room. There was no evidence an investigation was completed to identify how R54 was accessing alcohol. A progress note dated 4/8/16 at 9:49 p.m. identified R54 had fallen and was found on his back. No injuries were noted and R54 denied pain. R54's pupils were dilated and smelled like he was drinking alcohol. R54 denied drinking alcohol and refused to do a breathalyzer. Neuro checks were started, blood pressure running low and director of nursing notified. Initial blood pressure 128/72 and pulse 87. Blood pressure 94/56 and pulse 88 at 9:35 p.m. The facility did not provide the corresponding Comprehensive Fall Report Form for this incident. A progress note on 4/9/16, indicated R54 continued to smell of alcohol and had three full Gatorade bottles at the bedside. The corresponding IDT progress note dated 4/11/16, indicated R54 was re-educated on alcohol policy, with active discharge planning. No other interventions to assist with ensuring R54's safety when drinking alcohol. R54's Monthly Nursing Assessment dated 4/19/16, indicated R54 had been drinking alcohol within the last month and was not a member of the gazebo program. The assessment also identified that R54 had a history of falling while	F 323		

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F 323	Continued From page 63 drinking and refused a breathalyzer when he smelled of alcohol. R54's Comprehensive Fall Report Form dated 4/23/16, identified R54 was found on the floor near his bed and he smelled like he had been drinking. R54 was not injured. His blood pressure was 116/65 with a pulse of 75. Immediate interventions included increased level of supervision, call light in reach and encourage resident to keep walker within reach. The investigation section identified all falls to this point resident has smelled of alcohol and refuses a breathalyzer. The final analysis and plan included continue to search resident upon returns to the building and remind again of alcohol policy. The corresponding progress note dated 4/23/16, identified that R54 smelled of alcohol and refused a breathalyzer test and neuro checks were started due to unwitnessed fall. The corresponding IDT review progress note dated 4/25/16, indicated staff were to continue to search R54 for alcohol and remind him of the alcohol policy. There were no interventions identified to assist with R54's safety related to his alcohol consumption. R54's Fall/Safety Risk Evaluation and Assessment dated 3/10/16, indicated the most recent fall for R54 was 3/3/16. R54 was assessed to be a high fall risk due to a recent alcohol consumption resulting in a fall without injury and the alcohol policy and procedures were reviewed with the resident. No other interventions to ensure R54's safety were identified. On 5/11/16, at 2:22 p.m. R54 was observed to be sleeping in his room. R54 was dressed appropriately with a four wheeled walker at the	F 323		

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F 323	Continued From page 64 bedside. On 5/11/16, at 2:10 p.m. the resident monitor (RM)-A stated that there were residents identified that needed their bags checked upon return to the facility. RM-A stated he searched their bags but did not "frisk" the residents. If alcohol was found on the residents we let the charge nurse know. RM-A further stated that he looked for residents stumbling or smelling of alcohol. R54 was on the list to be searched upon return to the facility, but RM-A had never found alcohol on him. When interviewed on 5/16/16, at 1:09 p.m. R54 stated he occasionally had some drinks, but can not drink at the facility because he was not part of the gazebo club. R54 denied drinking, however stated the nurses have asked him to do a breathalyzer when he returned to the facility, without explaining why. R54 further stated none of the facility staff members have ever asked him about his drinking history or whether he wanted to continue drinking. R54 continued to explain that he had problems with drinking in the past, more than socially, just for something to do. On 5/10/16, at 3:38 p.m. trained medication assistant (TMA)-B explained the gazebo program. TMA-B stated the social worker did an assessment before residents could join the program. The resident had to agree to the rules of the program and if approved could participate in the program on a daily basis. Everyday prior to participating in the program the resident came to the nursing station and took a breathalyzer if it showed they haven't been drinking they can participate in the program. After the program the residents that participated have an assessment to see if they can count backward from ten. R51	F 323		

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F 323	Continued From page 65 was part of the gazebo program, however TMA-B had seen R51 intoxicated after returning to the facility from a pass for the day with friends or family. TMA-B stated that she had seen this two to three times and he often refused a breathalyzer when he came back. When R51 refused a breathalyzer his medications were held and he was sent to bed to sleep it off. For "punishment R51 could not participate in the gazebo program for a week, but sometimes the punishment is only three days, it varies." TMA-B stated that if a resident was intoxicated vital signs should be checked for twenty-four hours and complete checks every fifteen minutes for a time. TMA-B further stated sometimes R51 refused. The front desk was supposed to check for alcohol when residents return from leave. On 5/12/16, at 10:41 a.m. TMA-C stated R51 smelled like alcohol, but alcohol hasn't been found on him. On 5/12/16, at 10:46 a.m. NA-O stated that R11 came back to the facility and had been drinking. NA-O also stated that R11 had snuck alcohol back into the facility. NA-O stated it happened one to two times per month. NA-O stated in the past residents used to be sent to detox when they had been drinking, but the facility doesn't do that anymore. NA-O stated R51 drank with the gazebo program but had been known to drink outside of the program as well. On 5/11/16, from 3:02 p.m. to 5:02 p.m. the DON, SSD, and administrator were interviewed together. The SSD stated that generally speaking if a resident was intoxicated, vital signs were done and the resident was asked to lay down. The DON stated the resident should be closely	F 323		

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F 323	Continued From page 66 monitored by checking on them frequently. The DON did not define frequently. The administrator indicated the frequency would be at the nurse's discretion, and confirmed frequent monitoring had not been completed for these documented incidences of alcohol use. The administrator further verified after discussing the issues of compliance related to the residents on the Gazebo program, and the residents drinking while out of the facility, that the facility's documentation was lacking assessment and consequences of non-compliance. The adminsitrator stated there needed to be more documentation and that he was unaware of the extent of the drinking at the facility until they'd started talking with staff for education after the IJ was called. The DON stated all residents on the first floor have the potential to go out of the facility and come back intoxicated, but not all residents have the motivation to do so. The DON also stated that she or the SSD were to be notified of any incidents involving alcohol, including the amount of alcohol, and an incident report should be completed. She indicated the facility needed a plan, so there was consistency among the nurses. The SSD stated, "It needs attention, as we do have concerns for their safety." On 5/16/16, at 1:37 p.m. the SSD stated there was no documentation for any level changes with R51 or R54. No specific written assessment was completed to determine levels, just an informal assessment with the IDT. The SSD said the IDT included social service and nursing, and sometimes a therapy staff if the resident was in therapy. "We look at behaviors and cognition and see how they are doing with both of these. Any changes would be made on the level sheet." The SSD verified being responsible for making any	F 323		

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F 323	Continued From page 67 changes to the care plan regarding the levels. "The residents are expected to sign out when they leave the building on a sheet with the resident monitors at the front door. Residents are allowed to leave the building based on their level privileges, which determines their safety level when leaving the building. However, there is no official assessment to determine the levels." When interviewed on 5/17/16, at 12:50 p.m. the social services director (SSD) stated part of her role with chemically dependent residents is determining their history. The SSD stated during the initial care conference, she lets the interdisciplinary treatment team (IDT) know what is appropriate for the individual resident. The SSD acknowledged if residents drink "too much" they could be a danger to themselves or others, but was unable to state what "too much" was, but stated definitely if they get alcohol poisoning, or if R51 would have a seizure, that would be too much. The IJ that began on 5/12/16, was removed on 5/17/16, when the facility ensured assessments for alcohol use and safety had been completed, care plans for the identified residents had been updated, policies had been revised and/or developed, an intoxication/impairment assessment tool was developed, and it could be verified by interview that staff had been educated regarding these interventions.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325		

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F 325	Continued From page 68 (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nutritional interventions had been consistently implemented for 1 of 1 residents (R44) in the sample reviewed for weight loss. Findings include: R44's order summary report dated 5/2/16, indicated R44's diagnoses included dementia, cerebral vascular accident (CVA), dementia, and left humerus fracture. An admission Minimum Data Set (MDS) dated 1/26/16, indicated R44 weighed 157 pounds, required supervision and set up assistance with eating and had deficits with chewing or swallowing. The MDS indicated R44's cognition was moderately impaired. A weights and vitals summary listed R44's weight on 1/19/16, to be 157 pounds and on 4/4/16, 141 pounds (a 16 pound weight in less than 3 months since admission). The physician order summary dated 5/2/16, indicated R44 was ordered the house supplement, two ounces, three times a day. The Medication Administration Record (MAR) dated 1/16 through 4/16, did not indicate how much supplement was taken by R44 only that it was given.	F 325	Mission strives to ensure that residents maintain body weight and other clinical levels and will receive a therapeutic diet if their clinical condition causes a nutritional problem. 1. R44t's and all other residents receiving supplements and their amounts were added to the MAR 2. Nurse Manager or designee will audit MAR documentation of amount consumed weekly for residents on supplements for four (4) weeks. 3. TMA will be responsible for dispensing nutritional supplements to the residents as ordered, also monitoring and documenting actual consumption. 4. Licensed nurses and TMA's will be educated on the process for dispensing and documentation for residents requiring nutritional supplement. Responsible: DON & Nurse Managers Audit outcomes will be reviewed by QA Committee for compliance and/or implementing an action for any identified issue.	6/27/2016

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F 325	Continued From page 69 A dietitian note dated 3/7/16, indicated R44 had not maintained weight since admission and had a significant weight loss. The dietitian note indicated R44 appeared at moderate to high risk with weight loss. A dietitian note dated 4/21/16, indicated R44 remained at high risk and was unable to maintain weight. R44's care plan dated 4/2/16, identified the following problem: Resident appears at high risk nutritionally due to significant weight loss in one month, skipping breakfast, dementia, and increased needs for healing fracture. The plan directed staff to provide house supplements as ordered, Magic cup two times a day with meals, monitor R44 at meal rounds, offer R44 to eat Magic cup in the morning, record daily intake of meals and if R44 refuses to have staff feed R44. On 5/9/16, at 5:55 p.m. R44 was observed sitting in the dining room next to R69. R44 was observed giving R69 the Magic cup. Nursing assistant (NA)-N stated "no no don't do that" when R44 gave R69 the Magic cup but made no attempt to stop it. NA-N did not offer R44 a different supplement. NA-N stated R44 gave the Magic cup to R69 "a lot". On 5/16/16, at 12:57 p.m. R44 was eating in the dining room with other residents at the table. R44's Magic cup was opened and sitting on the table with a few bites gone from the cup. An interview on 5/16/16, at 1:22 p.m. with trained medication assistant (TMA)-A indicated TMA-A gave R44 the Magic cup and gave him a few bites. TMA-A stated sometimes R44 took the Magic cup and other times it was declined. TMA-A stated the documentation of intake was not done on the computer by the TMA-A, but was recorded by the dining room staff. On 5/16/16, at 1:27 p.m. R44 was in the small day room with the television on and other	F 325		

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F 325	Continued From page 70 residents in the room. R44 stated lunch was fair. TMA-A was observed to come into the small day room with R44's Magic cup and fed R44 the rest of the Magic cup from the dining room. TMA-A had to encourage R44 to eat the Magic cup. On 5/16/16, at 1:35 p.m. licensed practical nurse (LPN)-A looked at the meal monitoring book for the second floor. There were no intakes written down for the resident's lunch intake. LPN-A stated lunch was done and the tables were clean now, so staff didn't know if R44 took the Magic cup or not. On 5/16/16, at 2:04 p.m. registered nurse (RN)-A stated the amount of the supplement taken by the resident should be documented in the MAR. On 5/16/16, at 3:00 p.m. the dietary manager (DM) stated R44's diet card was looked at to see if R44 was receiving the Magic cup. The DM stated staff talk to each other to see if R44 was eating the Magic cup. There was no specific documentation of a separate intake with the Magic cup. The DM stated nursing or dietary made sure R44 did not give the Magic cup to other residents. The DM indicated R44 took 25 to 50 percent of the meals, that is "my visual assessment." The DM stated R44 was considered at risk for weight loss and had lost weight. A facility policy Nutrition High Risk Monitoring dated 5/16/14, indicated intake of supplements will be recorded in the MAR.	F 325		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal	F 334		

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	245546	A. BUILDING _____ B. WING _____	05/17/2016

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F 334	Continued From page 71 representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	It is facility policy that all residents will be offered influenza immunization. Before receiving the immunization the resident or their legal representative will receive education which will be documented along with whether they received immunization or not. R68's immunizations were discussed with the attending physician. Resident will receive with 2016 season. All residents' immunization status will be reviewed. If identified as not current new consents will be obtained & immunization administered. Random weekly audit will be initiated by the Nurse Manager or designee of resident's immunization record to assure immunization and consents are documented and given as ordered. All licensed nurses will be educated on process for completing immunizations and required documentation. Responsible: Nurse Managers Audit outcomes will be reported to the QA committee monthly for three (3) months, as well as reviewed in Infection Prevention & Control Committee. Responsible: DON	7/27/2016

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F 334	Continued From page 72 documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain documentation of vaccination status for 1 of 5 residents (R68) reviewed for influenza vaccination status. Findings include: R68 was admitted to the facility on 7/30/15. A consent to receive the influenza vaccination was signed by R68 on the date of his admission. This gave the facility consent to administer the vaccination annually in the fall, unless there were medical contraindications. The consent did not have a facility representative signature on it. An untitled and undated schedule of vaccinations directed staff to "Give flu vacc. [vaccine] 0.5 ml	F 334		

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F 334	Continued From page 73 [milliliters] IM [intramuscular], per MD orders if no allergy to eggs. Document on vaccination record when given." No administration date was documented, instead "give in the fall" was hand written on the sheet. An additional influenza vaccination consent, signed 9/29/15, was reviewed for R68 and contained a facility representative's signature. Again, no additional documentation was in R68's medication record as to whether or not the influenza vaccination was administered. R68's quarterly Minimum Data Set (MDS) dated 1/27/16, indicated R68 had not received the influenza vaccination during the influenza season. On 5/13/16, at 2:22 p.m. the director of nursing (DON) stated residents were able to give consent for the influenza vaccination if they were their "own person." The DON was unaware if R68 had received the influenza vaccination. The DON was attempting to find more information in his paper MAR. On 5/16/16, at 11:16 a.m. any further information regarding R68's vaccination status was requested. No further documentation was provided. The Mission Nursing Home Nursing Orders, revised 4/20/10, stated under INFLUENZA VACCINE, "May have yearly flu vaccine 0.5 ml (IM) as recommended by Minnesota Health Dept. unless allergic to eggs and or acute illness/infection." The facility policy, Influenza Vaccine Program, revised in 2013, directed staff to screen every	F 334		

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F 334	Continued From page 74 new admission, administer the vaccine if indicated, and record the vaccination in the medical record as well as the vaccination record.	F 334		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an individualized service plan was included as part of the assessment and care planning process for 1 of 1 resident (66) reviewed for Preadmission Screening and Resident Review (PASARR). Findings include: R66's admission Minimum Data Set (MDS) dated 3/10/16, indicated R66 was cognitively impaired. R66's Order Summary Report dated 5/9/16, included diagnoses of unspecified intellectual disabilities, impulse disorder, conduct disorder and anxiety disorder. R66's care plan dated 3/11/16, indicated R66 had an alteration in cognitive status related to a diagnosis of mental retardation.	F 406	Social Worker has been working with Hennepin County regarding resident's level II screening which indicated a need for active treatment and for him to follow an ISP. SW spoke with Nancy King and her supervisor. They indicated he has not been under active case management and there is no ISP in Place. They believe he does not need active case management due to Medical issues and need for nursing home placement. They did schedule a date earlier this month to come out and do his annual screening which is due in July. They were not able to come out sooner and will be here on July 7, 2016 at 10am. They will complete a new level II screening at that time. They will also change the screening to indicate he does not need active treatment at that time unless they feel there have been changes in his condition. DSS will review all residents for Level II PASRR and ensure that it is being followed as indicated.. DSS will review all Level II's to ensure service plan is being followed. Will review monthly for three months then quarterly until QA determines compliance. Responsible: DSS	7/15/2016

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F 406	Continued From page 75 R66's Evaluative Report Level II Preadmission Screening and Annual Resident Review (PASARR) indicated R66 was evaluated on 8/8/14. R66's proposed date of admission to the facility was 2/3/11. The Level II PASARR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASARR further indicated: "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." R66's medical record lacked an individual service plan (ISP) by the local agency. When interviewed on 5/12/16, at 7:54 a.m. the medical record coordinator stated that R66's Level II PASARR was accepted as it was from R66's previous facility and that the county does not repeat Level II PASARR's unless the resident had been placed back into a community setting. When interviewed on 5/12/16, at 8:37 a.m. licensed social worker (LSW)-B verified that R66's PASARR was completed on 8/8/14, and did not have an annual review. LSW-B stated to determine individual services the facility waited to see what issues the resident had and then made a referral to psychiatry. In addition, medications were reviewed by the interdisciplinary team (IDT) for appropriate medications. LSW-B stated currently staff was directed to set boundaries and redirect R66 when inappropriate. On 5/12/16, at 12:35 p.m. LSW-B verified the	F 406		

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F 406	Continued From page 76 facility did not have a current ISP to ensure active treatment was being provided as directed by the PASARR and stated that R66 does not have an ISP because he resided in a nursing facility and not a group home setting. On 5/13/16, at 9:36 a.m. the LSW-B stated that he had contacted the county today and R66 did not have an active social worker with the county and did not have an active ISP. The county was updating their software. LSW-B further stated R66 was last assessed by the county in 2015 and the facility did not have the most recent assessment on file. LSW-B had requested a copy from the county. The county faxed the most recent Evaluative Report Level II PASARR to the facility, which indicated R66 was re-evaluated on 7/1/15. R66's proposed date of admission to the facility was 2/3/11. The Level II PASARR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASARR further indicated "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." No ISP was included in the information from the county. A policy for Level II PASARR was requested and none was provided by the facility.	F 406		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 77 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 441	Mission Nursing Home has established and implemented an infection control program under which it: investigates, controls, & prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents & corrective actions related to infections. To assure continued compliance the following plan has been implemented: The resident infection tracking form will be continued. Use of the infection tracking form will be completed at the time of discovery. Nurse Managers will review all new orders to ensure all infections and cultures are documented on the log. The infection tracking will be reviewed weekly in the Interdisciplinary Team Meeting (IDT) Infection control tracking will be reviewed, analyzed for trends, discussed and evaluated in the monthly Infection Prevention & Control Committee (IPACC), and presented to the QA committee at each meeting. Responsible: DON	7/29/2016

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F 441	Continued From page 78 facility failed to develop a comprehensive infection control program that included comprehensive surveillance of resident symptoms and cultures and analysis of that surveillance. This had the potential to affect all 85 residents residing in the facility. Findings include: During review of the facility's Monthly Infection Control Logs from 3/15 to 5/16, the following infections were identified: 9 urinary tract infections (UTI's), 17 respiratory infections, 11 cellulitis/wound infections, and 2 unidentified infections. All UTI and respiratory infections were treated with antibiotic therapies, however, the logs lacked evidence of cultures and symptom tracking to support antibiotic use. Antibiotics were either changed or extended on 2 UTI's and 3 respiratory infections (excluding aspiration pneumonia) without evidence of cultures/symptoms to support the change or extension of antibiotic therapies. The logs identified antibiotic changes for 1 UTI and 1 respiratory infection occurred due to hospitalization or "acquired healthcare." The facility lacked any documented analysis of the surveillance infection control logs. On 5/13/16, at 2:37 p.m., the director of nursing (DON) stated the infection control logs were filled out by the floor nurses as the infections occurred. The logs were reviewed by her and in their monthly quality assurance (QA) meetings, but she did not have a written analysis of the surveillance. The DON stated she received a list of antibiotics the first week of every month for the previous month. She also noted the antibiotic changes that occurred while residents were	F 441		

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F 441	Continued From page 79 hospitalized and stated the expectation would be to obtain the cultures and document on the logs. She further stated symptoms were documented in the residents' progress notes. No symptoms were documented on the logs. The facility policy Infection Control Program, revised in 2013, established the intent of the program was to "provide surveillance, investigation and monitoring to prevent, to the extent possible, the onset and the spread of infection." Furthermore, the policy identified surveillance/monitoring as to "review microbiology culture and sensitivity reports on a regular basis to identify types of organisms causing infections, monitor for antibiotic resistant organisms, and identify potential transmission of organisms between residents" and to "perform surveillance for infections, compile and analyze data, prepare and bring reports to the Infection Control oversight committee."	F 441		
F 490 SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure administration effectively addressed concerns of neglect and potential injury for 3 of 3 residents (R11, R51, and R54) reviewed who were consuming alcohol in an	F 490		

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F 490	Continued From page 80 unsafe manner. Findings include: Refer to: F323. The facility neglected to comprehensively assess, develop interventions, and ensure safety measures were in place to protect 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated resulting in unsafe behavior. The facility failed to ensure interventions were in place to prevent significant injury to R11, R51, R54 and/or others. On 5/11/16, at 3:02 p.m. the administrator verified after discussing the issues of compliance related to the residents on the Gazebo program, and the residents drinking while out of the facility, facility documentation was lacking assessments and the consequences of non-compliance. There needed to be more documentation. On 5/17/16, at 2:44 p.m. the administrator stated there have been some discussions related to R11. The discussions did not involve outings and returning intoxicated, but sneaking alcohol back into the facility. He also verified being involved in a couple of check-ins with R11. Social Services Director (SSD) had completed the breathalyzer on R11 on these occasions. He stated, "If we know about an issue, we address it." The administrator added he was involved in the staff training over the weekend, and this was when he heard of the amount of issues related to drinking, that he was not aware of. He also stated the change has to be immediate. The staff are wanting to help, seeing that it is important. Related to R51, administrator stated he was not aware of the resident being taken by the police on	F 490	Mission Nursing Home has staff training clarifying the communication procedure of resident intoxication incidents being called to the Administrator (including: frequency, severity, circumstance, residents having more incidents than others etc). The IDT incident report meeting, which Administrator will attend, will include a standing agenda item reviewing any resident intoxication incidences. *see F323 for additional information Responsible: Administrator	7/1/2016

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F 490	Continued From page 81 12/4/15, but was made aware of it prior to survey, further stating R51 has been taken to detox, is back, and is better. Administrator was not aware of any special recommendations implemented for the residents, or of any additional care conferences being held. The administrator also stated being unaware of the extent of the drinking at the facility until they started talking with staff for education after the IJ was called.	F 490		
F 493 SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure adequate oversight of managerial staff and facility practices related to implementation and development of alcohol and drug use policies and practices to ensure the health and safety of all residents who consumed alcohol. This deficient practice affected 3 of 3 residents (R11, R51, R54) who were consuming alcohol in an unsafe manner, and the potential to affect any other residents who consumed alcohol while residing in the facility. Findings include:	F 493		

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F 493	Continued From page 82 Refer to: F323. The facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated resulting in unsafe behavior. This resulted in an immediate jeopardy situation for R11, R51, and R54. Refer to: F490. The facility failed to ensure administration effectively addressed concerns of potential neglect of care and potential injury for 3 of 3 residents (R11, R51, and R54) who were consuming alcohol in an unsafe manner. Refer to: F501. The facility failed to collaborate with the medical director to address significant potential for serious injury for 3 of 3 residents (R11, R51, and R54) who were consuming alcohol in an unsafe manner. Refer to: F520. The facility failed to ensure the quality assessment (QA) committee recognized and developed action plans to address neglect of care and potential for injury for 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated. During interview on 5/17/16, at 3:20 p.m. governing board member (GBM) stated she was not aware of any drinking problems that were going on at the facility, or of residents drinking off site and returning to the facility under the influence of alcohol and staff not monitoring for their safety. GBM stated she would hope that if the administration was aware of these issues, they would be brought to the governing board. Further, GBM stated the governing board meets	F 493	Mission Nursing Home and its board provides proper protocols and policies to ensure the safety and security of its residents. The board of directors will be informed by the administrator and executive director of any resident intoxication event that meets the updated resident intoxication procedures. In addition, the board agenda will include the addition of reviewing this topic at its board meetings. * see F323, F490, F501, F520 for additional information Responsible person: Mission Nursing Home Administrator Completion Date: May 20, 2016	

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MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(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 493	Continued From page 83 monthly, with the exception of August, and other meetings are held at times that may not include the entire board. She asked for a copy of the policy being revised, and stated the board would be comfortable in asking for revisions on this policy. A discussion would be held if any revisions were necessary. Facility policy regarding the governing board responsibilities was requested, but not provided.	F 493		
F 496 SS=F	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related	F 496	Mission will ensure that all nursing assistants currently employed or applying for a position are listed on the State's Nursing Assistant Registry and the required training. This will be accomplished by: 1. Employees mentioned in the survey were suspended pending certification. 2. Current NA's will be verified that they are on the registry. New applicants will be verified on NA registry by the Staffing Coordinator or designee, prior to job offer. 3. Check registry when annual evaluations completed. Responsible: Nurse Manager 4. Audits will be conducted on all new hires to ensure all required verifications are completed. Results of audits will be presented to QA until determined compliant. Responsible: DON	7/25/2016

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F 496	Continued From page 84 services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 34 nursing assistants (NA-K, NA-I), currently employed by the facility were listed on the State's Nursing Assistant Registry as required. This had the potential to affect all 85 residents residing in the facility. Findings include: NA-K was hired on 2/3/16. NA-L was hired on 11/10/15. A review of the nursing assistant registration with the State Nursing Assistant Registry indicated NA-K and NA-L were no longer active on the registry. On 5/13/16, at 3:40 p.m. via telephone a representative from the state agency verified NA-K was removed from the registry as NA-K had attended an unapproved nursing assistant course and needed to re-test to be placed back on the registry. NA-L had been on the registry, however, the certification expired on 4/29/16. NA-L needed to complete the steps to be placed back on the registry. In addition, both NA-K and NA-L should not be working as a nursing assistants in the facility until back on the registry. On 5/17/16, at 11:45 a.m. the director of nursing	F 496		

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F 496	Continued From page 85 (DON) stated she was unaware that NA-K had been removed from the registry due to attending an unapproved training course. The DON stated a listing of unapproved training course was posted near the time clock and in the break room for nursing assistants to review. The DON expected that NA-K would have reviewed the list and reported to her about attending an unapproved course. In addition, the DON stated the previous staffing coordinator, who left the facility in November or December of 2015, was responsible for submitting hours worked to the registry and verifying nursing assistant certification status. This had not been completed since the staffing coordinator left.	F 496	M	
F 497 SS=F	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete annual performance	F 497		

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F 497	Continued From page 86 evaluations and ensure 12 hours of annual in-service training was completed for 8 of 8 nursing assistants (NA-C, NA-D, NA-E, NA-F, NA-G, NA-H, NA-I, NA-J) employed by the facility greater than 12 months. This had the potential to affect all 85 residents residing in the facility. Findings include: NA-C was hired on 8/8/13. NA-C's personnel file was reviewed and the last performance evaluation completed for NA-C was 10/6/14. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-D was hired on 7/28/14. NA-D's personnel file was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-E was hired on 7/11/12. NA-E's personnel file was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-F was hired on 7/29/14. NA-F's personnel file was reviewed and the last performance evaluation completed for NA-F was 10/10/14. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-G was hired on 5/9/13. NA-G's personnel file was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of	F 497	Mission Nursing Home's policy is to complete reviews of every nursing assistant at least once every twelve (12) months and provides regular inservice education based on the outcome for these reviews. To assure continued compliance, the following plan has been implemented. 1. Performance evaluations will be completed for NA-C, NA-D, NA-E, NA-F, NA-G, NA-H NA-I, NA-J & placed in their personnel file. 2. DON/designee has reviewed personnel files of all NAR's to check for timely performance evaluations and evidence of continuing education requirements. 3.Performance evaluations for NAR's who have not had one within the last 12 months have been assigned and will be completed. DON & Nurse Managers will complete evaluation reviews.. HR will track inservice attendance and completion of makeup tests to ensure all nursing staff complete requirements. HR will do random employee file audits a minimum of 3 per week to ensure inservice & evaluation compliance. Results will be brought to each QA committee meeting. Responsible: HR	7/29/16

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F 497	Continued From page 87 in-service training per year. NA-H was hired on 7/11/13. NA-H's personnel file was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-I was hired on 8/9/13. NA-I's personnel file was reviewed and the last performance evaluation completed for NA-I was noted at the top of the page to be 2014 without a specific date of completion. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-J was hired on 2/28/13. NA-J's personnel file was reviewed and the last performance evaluation completed for NA-J was 6/16/14. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. On 5/16/16, at 11:10 a.m. the human resources/administrative assistant (HR)-B verified that NA-C, NA-D, NA-E, NA-F, NA-G, HA-H, NA-I, NA-J did not have current performance evaluations within the last year. In addition, HR-B stated that performance reviews should be conducted annually. HR-B stated that an in-service is completed monthly that nursing assistants are required to attend. If they do not attend the in-service they are provided written documentation and a test. HR-B further stated that there is no process in place to ensure the education had been completed and no monitoring of the total hours of the continuing education completed by staff.	F 497		

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F 497	Continued From page 88 On 5/17/16, at 11:45 p.m. the director of nursing (DON) stated each department head took turns teaching monthly education. However, there was not a process in place to ensure education was completed. Currently, hours were only tracked for infection control classes. The DON acknowledged performance reviews were not up to date. The undated Employee Performance Evaluation Instructions indicated performance evaluations were to be completed annually during the employee's anniversary month, and were to be completed the employee's supervisor.	F 497		
F 501 SS=D	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director to address concerns related to significant issues for 3 of 3 residents (R11, R51, and R54) reviewed who excessively consumed alcohol. Findings include: See F323. The facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 3 of 3 residents (R11,	F 501	Mission Nursing Home and its Medical Director provides proper protocols and policies to ensure the safety and security of its residents. The Medical Director is now meeting at each site visit with either the Director of Nursing or Administrator to review resident intoxication events. When necessary, given severity, the Medical Director will be called on resident intoxication matters. In addition, the QA committee meeting now holds a standing agenda item related to resident intoxication events. Problem solving and quality improvement will occur at the QA meetings. (continued next page)	7/21/2016

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F 501	Continued From page 89 R51, and R54) who excessively consumed alcohol and regularly became intoxicated. This resulted in an immediate jeopardy situation for R11, R51, and R54. When interviewed on 5/17/16, at 2:58 p.m. the medical director (MD) stated he is not the primary physician for any of the residents at the facility, but is the medical director. MD denied being aware that any of the residents were drinking outside of the gazebo program, stating "and that bothers me." Nothing has been brought up to him about residents drinking. Further MD stated when the program was held outside, there were issues discussed, and brought into the quality assurance meetings. He stated he was aware there are occasionally people that go out to drink, but was not aware there was a problem, but more of an isolated issue. MD also stated he was not aware of residents repeatedly not following the rules. He would expect there be an incident report filled out, and the incident reports specifically related to alcohol be brought to him for review. When reviewing the breathalyzer results of the residents, MD stated be was "agast" that nursing did not do a report on these. Years ago, MD stated he suggested the breathalyzer, and expected there was a policy in place as to what to be done with the specific readings. MD stated the facility has not reached out to him for assistance in what to do if residents are refusing breathalyzers tests. A result of 0.256, would indicate substantial drinking, with the person quite intoxicated and at risk for falling. At 0.307, would indicate an increased risk of falls. There is also potential of issues with the resident's medications. MD stated he was not aware of anyone refusing a breathalyzer, identifying they cannot allow nothing to be done. The delima is	F 501	R11, R51, R54 were discussed at the 5/17/2016 QA committee meeting with Medical Director in attendance. Monthly audit will occur through review of the Medical Director site visit notes and QA committee minutes. Responsible : DON	7/21/2016

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F 501	Continued From page 90 what to do if someone is not cooperative. The real issue is monitoring, and the facility has to pay more attention to prople leaving the building. There needs to be a policy on monitoring residents that are intoxicated. Door monitors need to be more accountalbe. The high risk residents need to be monitored, incident reports completed, and they need to be brought to quality assurance. Medical Director Agreement signed 6/10/13, identified the provider is responsible for the overall coordination of medical care at the facility. Coiodination of care means provider shares responsibility for assuring facility is providing appropriate care as required which involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and medical care of residents.	F 501		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		

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F 520	Continued From page 91 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. 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) committee recognized and developed action plans to address potential neglect of care and potential for injury for 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated. This had the potential to affect any residents who consumed alcohol in unsafe levels. Findings include: Refer to: F323. The facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated in an unsafe manner. This resulted in an immediate jeopardy situation for R11, R51, and R54). On 5/17/16, at 2:35 p.m. the administrator was interviewed regarding the facility's Quality Assessment and Assurance (QA&A) program. The administrator stated drinking at the facility and alcohol use has not been specifically brought to the QAA meetings, further stating it was not	F 520	Alcohol specific related incidents, including R11, R51, R54 will be added to the quality assurance agenda (report including: frequency, severity, circumstance, residents having more incidents than others, certain dates, one resident obtaining for others) Will be addressed at the next QA committee (including Medical Director, Pharmacist & Department Managers) meeting by 5/27/2016 Responsible: DSS, Admin Assistant	5/27/2016

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F 520	Continued From page 92 getting brought to us "to a point requiring attention." The plan for future meetings is to have active discussion about safety and drinking. He identified there had been a lot of discussion since the IJ was called, and later this afternoon, they were holding a special QAA meeting for the sole purpose of discussing safety and drinking. Further, the administrator stated resident levels are not discussed at these meetings. Facility policy related to QAA was requested but not provide.	F 520		

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

PRINTED: 06/06/2016
FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on May 10, 2016. At the time of this survey, Mission Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	It is the policy of Mission Nursing Home to follow all Federal, state, and local guidelines, laws, regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with the citations. The preparation, submission and implementation of this correction will serve as our credible allegation of compliance.	

APPROVED
By Tom Linhoff at 10:12 am, Jul 08, 2016

RECEIVED
JUL - 6 2016
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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

ADMINISTRATOR 7/1/16

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 2-story building was constructed in 1995 and was determined to be of Type II (111) construction. It has a full basement and is automatic sprinkler protected throughout. The facility has a fire alarm system that is monitored for fire department notification. The facility has a capacity of 94 and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership.	K 050		

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K 050	Continued From page 2 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 91 residents. Findings include: On a facility tour between the hours of 09:30 AM and 1:30 PM on May 10, 2016, observation revealed that the fire alarm was not tested the day after silent drills were conducted. This deficient practice was confirmed by the Director of Maintenance at the time of inspection.	K 050	It is the policy of Mission Nursing Home to assure proper fire drill documentation is in place and available for review, specifically next day fire alarm testing after an overnight fire drill where no audible alarm was sounded. For the month June, the night shift fire drill was conducted by the Environmental Service Director including coming back the next day fully test the fire alarm system. In addition, the fire alarm company verified the fire alarm system was operational the next day. Person Responsible: Environmental Services Director Completion Date: June 25, 2016	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all 91 residents. Findings include: 1. On a facility tour between the hours of 9:30 AM and 1:30 PM on May 10, 2016, observation revealed that the facility could not provide documentation of quarterly automatic sprinkler system flow testing. 2. On a facility tour between the hours of 9:30 AM and 1:30 PM on May 10, 2016, observation revealed that the automatic sprinkler system pressure gauges were last calibrated on 04/19/2011 which are past the 5 year criteria. 3. On a facility tour between the hours of 9:30 AM and 1:30 PM on May 10, 2016, observation revealed that the last internal pipe inspection on the automatic sprinkler system was conducted on 04/19/2011 which is passed the 5 year criteria. This deficient practice was verified by the Director of Maintenance at the time of inspection .	K 056	It is the policy of Mission Nursing Home to assure proper sprinkler system documentation is in place and available for review, specifically quarterly automatic system flow testing. Ahern Fire Protection will conduct the following work: Quarterly automatic sprinkler system flow testing, calibration/ replace of sprinkler system pressure gauges, internal pipe inspection. Person Responsible: Environmental Services Director Completion Date: July 14, 2016	
K 064 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD	K 064		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245546	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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K 064	Continued From page 4 Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition and NFPA 10. This deficient practice could affect all 91 residents. Findings include: On a facility tour between the hours of 9:30 AM and 1:30 PM on May 10, 2016, observation revealed that annual portable fire extinguisher inspections were conducted in September 2015 per inspection tags, however there was no service report kept on file at the facility. This deficient condition was verified by the Director of Maintenance at the time of inspection.	K 064	It is the policy of Mission Nursing Home to assure proper fire extinguisher servicing documentation is in place and available for review. Weber/Troseth (fire extinguisher company) will conduct its annual servicing and will include proper documentation of the servicing. Person Responsible: Environmental Services Complete Per (NA Mission NH) 7/6/16 07/08/16	
K 071 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.	K 071		

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	245546	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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K 071	Continued From page 5 (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observations, the facility has a soiled linen chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and NFPA 82. This deficient practice could affect 42 residents. Findings include: On a facility tour between the hours of 09:30 AM and 1:30 PM on May 10, 2016, observation revealed that the laundry chute doors on the first and second floor laundry chute do not latch during self-closing. Manual manipulation of the latch is required for door to latch. This deficient practice was verified by the Director of Maintenance at the time of the inspection.	K 071	It is the policy of Mission Nursing Home to a assure proper operation of all laundry chute doors with self latching features. Laundry chute latches on first and second floor have been replaced with a latch that will lock properly with out manual manipulation. Complete Per (NA Mission NH) 5/17/16 07/08/16	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	K 072		

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K 072	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of residents in an emergency situation. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on May 10, 2016, observation revealed that exit doors leading to stairways require a numerical keypad entry, however instructions for unlocking are not made available. These deficient practices were verified by the Director of Maintenance at the time of the inspection.	K 072	It is the policy of Mission Nursing Home to assure means of egress are free from obstructions or impediments, specifically the availability of the code for releasing the magnetized stairwell doors. The instructions on how to unlock the doors are posted next to the keypad, to ensure MNH stays in compliance. Person Responsible: Environmental Services Director Completion Date: June 30, 2016	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 91 residents. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on May 10, 2016, observation revealed that there was not a documented cool	K 144	It is the policy of Mission Nursing Home to assure proper generator maintenance documentation is in place. A disclaimer of 20 minutes cool down has been added to the generator log, Person Responsible: Environmental Services Director Completion Date: May 17. 20160	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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K 144	Continued From page 7 down period performed after the monthly generator load test was conducted. These deficient practices were verified by the Director of Maintenance at the time of the inspection.	K 144		
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did implement an automatic sprinkler system out of service policy in accordance with LSC (00) Section 9.7.6.1. This deficient practice could effect all 91 residents. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on May 10, 2016, observation revealed that the facility could not provide documentation of a automatic sprinkler system outage plan which contained a fire watch protocol. This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 154	It is the policy of Mission Nursing Home to have proper procedures and plans for the automatic fire sprinkler system. Mission Nursing Home has created a new automatic sprinkler system outage procedure. Copies have been placed at the nurses stations in the emergency procedure manual. Person Responsible: Environmental Services Director Completion Date: June 29, 2016	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of	K 155		

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	245546	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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K 155	Continued From page 8 service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not implement a fire alarm system out of service policy in accordance with LSC (00) Section 9.6.1.8. This deficient practice could effect all 91 residents. Findings include: On a facility tour between the hours of 09:30 AM and 01:30 PM on May 10, 2016, observation revealed that the facility could not provide documentation of a fire alarm system outage plan which contained a fire watch protocol. This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 155	It is the policy of Mission Nursing Home to have proper procedures and plans for the automatic fire sprinkler system. Mission Nursing Home has created a new automatic sprinkler system outage procedure that includes a fire watch protocol. Copies have been placed at the nurses stations in the emergency procedure manual. Person Responsible: Environmental Services Director Completion Date: June 29, 2016	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 6139
June 22, 2016

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, Minnesota 55441

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5546026 & H5546050

Dear Mr. Meyer:

The above facility was surveyed on May 9, 2016 through May 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5546050 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.

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

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

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 W Division #212, St Cloud MN, 56301. 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 Pam Kerssen, RN, APM at (218) 308-2129.

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.

Please feel free to call me with 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

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
June 6, 2016

Mr. Timothy Meyer, Administrator
Mission Nursing Home
3401 East Medicine Lake Boulevard
Plymouth, Minnesota 55441

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5546026 & H5546050

Dear Mr. Meyer:

The above facility was surveyed on May 9, 2016 through May 17, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5546050 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 Pam Kerssen, RN, APM @ (218) 308-2129.

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.

Please feel free to call me with 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

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00235	A. BUILDING: _____ B. WING _____	05/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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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 May 9th, 10th, 11th, 12th, 13th, 16th and 17th 2016, 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 190	MN Rule 4658.0060 B. Responsibilities of Administrator; policies The administrator is responsible for the: B. formulation of written policies, procedures, and programs for operation, management, and maintenance of the nursing home; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure administration effectively addressed concerns of neglect and potential injury for 3 of 3 residents (R11, R51, and R54) reviewed who were consuming alcohol in an unsafe manner. Findings include: Refer to: F323. The facility neglected to comprehensively assess, develop interventions, and ensure safety measures were in place to protect 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated resulting in unsafe behavior. The facility failed to ensure interventions were in place to prevent significant injury to R11, R51, R54 and/or others. On 5/11/16, at 3:02 p.m. the administrator verified after discussing the issues of compliance related to the residents on the Gazebo program, and the	2 190		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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2 190	Continued From page 3 residents drinking while out of the facility, facility documentation was lacking assessments and the consequences of non-compliance. There needed to be more documentation. On 5/17/16, at 2:44 p.m. the administrator stated there have been some discussions related to R11. The discussions did not involve outings and returning intoxicated, but sneaking alcohol back into the facility. He also verified being involved in a couple of check-ins with R11. Social Services Director (SSD) had completed the breathalyzer on R11 on these occasions. He stated, "If we know about an issue, we address it." The administrator added he was involved in the staff training over the weekend, and this was when he heard of the amount of issues related to drinking, that he was not aware of. He also stated the change has to be immediate. The staff are wanting to help, seeing that it is important. Related to R51, administrator stated he was not aware of the resident being taken by the police on 12/4/15, but was made aware of it prior to survey, further stating R51 has been taken to detox, is back, and is better. Administrator was not aware of any special recommendations implemented for the residents, or of any additional care conferences being held. The administrator also stated being unaware of the extent of the drinking at the facility until they started talking with staff for education after the IJ was called. SUGGESTED METHOD OF CORRECTION: The facility's administrator, along with the director of nursing, could review and revise facility policies and procedures related to alcohol consumption and resident safety. The administrator could ensure all appropriate staff are educated to the policies. The facility could ensure the administrator is updated on all alcohol related	2 190		

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2 190	Continued From page 4 incidents, and reviews all incident and grievance reports to ensure ongoing compliance by staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 190		
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) committee recognized and developed action plans to address potential for injury for 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated. This had the potential to affect any residents who consumed alcohol in unsafe levels. Findings include:	2 255		

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2 255	Continued From page 5 Refer to: F323. The facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 3 of 3 residents (R11, R51, and R54) who were consuming alcohol and becoming intoxicated in an unsafe manner. This resulted in an immediate jeopardy situation for R11, R51, and R54). On 5/17/16, at 2:35 p.m. the administrator was interviewed regarding the facility's Quality Assessment and Assurance (QA&A) program. The administrator stated drinking at the facility and alcohol use has not been specifically brought to the QAA meetings, further stating it was not getting brought to us "to a point requiring attention." The plan for future meetings is to have active discussion about safety and drinking. He identified there had been a lot of discussion since the IJ was called, and later this afternoon, they were holding a special QAA meeting for the sole purpose of discussing safety and drinking. Further, the administrator stated resident levels are not discussed at these meetings. Facility policy related to QAA was requested but not provide. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could review the quality assurance program, policies and procedures to ensure the appropriate programs/systems are being reviewed in a timely manner. The quality assurance committee could appoint staff to perform routine system(s) performance audits to identify areas that could be enhanced or improved on. The committee could then audit the systems in place and report to the committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 255		

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2 255	Continued From page 6 (21) days.	2 255		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to complete annual performance evaluations and ensure 12 hours of annual in-service training was completed for 8 of 8 nursing assistants (NA-C, NA-D, NA-E, NA-F, NA-G, NA-H, NA-I, NA-J) employed by the facility greater than 12 months. This had the potential to affect all 85 residents residing in the facility. Findings include: NA-C was hired on 8/8/13. NA-C's personnel file was reviewed and the last performance evaluation completed for NA-C was 10/6/14. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-D was hired on 7/28/14. NA-D's personnel file was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-E was hired on 7/11/12. NA-E's personnel file	2 300		

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2 300	Continued From page 7 was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-F was hired on 7/29/14. NA-F's personnel file was reviewed and the last performance evaluation completed for NA-F was 10/10/14. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-G was hired on 5/9/13. NA-G's personnel file was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-H was hired on 7/11/13. NA-H's personnel file was reviewed and lacked an annual performance evaluation. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-I was hired on 8/9/13. NA-I's personnel file was reviewed and the last performance evaluation completed for NA-I was noted at the top of the page to be 2014 without a specific date of completion. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. NA-J was hired on 2/28/13. NA-J's personnel file was reviewed and the last performance evaluation completed for NA-J was 6/16/14. In addition, the personnel file lacked documentation of the required 12 hours of in-service training per year. On 5/16/16, at 11:10 a.m. the human	2 300		

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2 300	Continued From page 8 resources/administrative assistant (HR)-B verified that NA-C, NA-D, NA-E, NA-F, NA-G, HA-H, NA-I, NA-J did not have current performance evaluations within the last year. In addition, HR-B stated that performance reviews should be conducted annually. HR-B stated that an in-service is completed monthly that nursing assistants are required to attend. If they do not attend the in-service they are provided written documentation and a test. HR-B further stated that there is no process in place to ensure the education had been completed and no monitoring of the total hours of the continuing education completed by staff. On 5/17/16, at 11:45 p.m. the director of nursing (DON) stated each department head took turns teaching monthly education. However there was not a process in place to ensure education was completed. Currently, hours were only tracked for infection control classes. The DON acknowledged performance reviews were not up to date. The undated Employee Performance Evaluation Instructions indicated performance evaluations were to be completed annually during the employee's anniversary month, and were to be completed the employee's supervisor. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and/or designee could review and revise the policies and procedures for nursing assistants training/in-service to ensure staff are recieving the needed number of hours. Human resources and the DON could collaborate on a system to monitor education hours and nursing assistant certificiations. The Quality Assessment and Assurance (QAA) committee could do random	2 300		

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2 300	Continued From page 9 audits to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 300		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		

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2 302	Continued From page 10 Based on interview and document review, the facility failed to provide residents and/or family members information regarding Alzheimer's Training staff received, who received training, frequency of training, and a description of the training provided. This had the potential to affect all 85 residents of the facility and their families. Findings include: A review of the facility documents "Dementia In-Service," indicated a live, interactive training was presented to facility staff on 4/8/16. The course modules included a summary of dementia (including the scope of the illness), a review of the seven stages of dementia, recognition of the symptoms for each stage, and caregiver approaches. The review of caregiver approaches included managing challenging behaviors, tips for communicating with individuals who have disease, and accommodating for their activities of daily living. A review the "Mission Nursing Home In-Service Sign-In" sheet, indicated facility staff from the all disciplines received this dementia training. During review of admission documents provided to the residents, the facility included no information regarding Alzheimer's training provided. Further, there was no evidence the information was provided electronically. During an interview on 5/13/16, at 1:50 p.m., the admission coordinator stated at the time of admission, residents were told there was no dementia unit, but stated every year "all staff receive training in dementia." She further stated the facility did not provide information about dementia training in writing to the consumers, and there was no information provided electronically.	2 302		

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2 302	Continued From page 11 The admission coordinator reported she "wasn't aware we had to do that." SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could review the facility's process to ensure Alzheimer's training is completed in a timely manner by both the facility and contracted nursing staff, and resident/interested parties are made aware of the dementia training provided to staff (who receives training, the frequency of training, and a description of the training topics). The administrator and/or designee could monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 302		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R66) was comprehensively assessed for Level II Preadmission Screening and Resident Review. Findings include: R66's admission Minimum Data Set (MDS) dated 3/10/16, incorrectly identified R66's requirement	2 550		

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2 550	Continued From page 12 for a Level II Preadmission Screening and Resident Review (PASRR) for residents with a mental illness, mental retardation or related illness. The MDS indicated that R66 had not been assessed for a Level II PASRR, and the MDS should have indicated the resident had been screened for a Level II PASRR. R66's Evaluative Report Level II Preadmission Screening for Persons with Mental Retardation or Related Conditions indicated R66 was evaluated on 8/8/14. R66's proposed date of admission to the facility was 2/3/11. The Level II PASRR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASRR further indicated " This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." When interviewed on 5/13/16, at 10:27 a.m. the director of nursing (DON) stated that it appeared there was an error in documentation, on the MDS and it should have been documented as yes. The DON further stated that individualized services were not provided according to the the Level II PASRR as the facility did not have the individualized service plan (ISP) from the county agency. If the MDS had been coded correctly the county could have been contacted for the ISP, so the facility could provide the needed services. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring that each individual resident's comprehensive assessment is accurately	2 550		

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2 550	Continued From page 13 completed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff accurately complete assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, and develop safety interventions related to alcohol consumption to reduce the risk of significant harm to residents or others, and to monitor for withdrawal for 3 of 3 residents (R11, R51, R54) who were known to consume alcohol, become intoxicated and who were not being medically monitored. This resulted in an immediate jeopardy (IJ) situation for R11, R51 and R54.	2 830		

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2 830	Continued From page 14 Findings include: The immediate jeopardy began on 7/1/15, when R51 had an extremely elevated breathalyzer reading and clinical symptoms without appropriate intervention. During review it was determined R11, R51, and R54 had the potential for significant harm due to multiple incidents of intoxication without intervention by the facility including comprehensive assessment and/or implementation of appropriate interventions based on facility protocols. On 5/12/16, at 3:54 p.m. the facility administrator, director of nursing (DON), and social services director (SSD) were notified of the IJ for R11, R51, and R54. The IJ was removed on 5/17/16, at 2:30 p.m., but noncompliance remained at an isolated scope and severity level, with actual harm that is not immediate jeopardy (Level G). The facility policy Alcohol and Drug Use, undated, identified: "Purpose: A primary mission of Mission Nursing Home is to provide care to residents who are chronically chemically dependent. While encouraging and supporting the efforts of residents to maintain sobriety, the facility also recognizes that some persons will relapse or continue to use alcohol and drugs. This policy is adopted to provide guidelines on the use of alcohol and drugs, with the goals of a safe and healthy environment in mind, while also supporting and encouraging sobriety." In addition the policy included: 1. Mission Nursing Home will support any and all efforts at sobriety and is available to give you assistance at all times. 2. In order to participate in the Gazebo program, the resident will be assessed by therapy, nursing, and the behavior management committee. 3. The use or possession of alcohol in the	2 830		

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2 830	Continued From page 15 building is not permitted. Random room searches are conducted to ensure there is no alcohol in the building. 4. Inappropriate behavior resulting from the use of alcohol will not be allowed and will be addressed according to the facility behavior management policy. The facility policy titled Behavior Policy, undated, indicated "violent, criminal or inappropriate sexual behavior in public will not be tolerated by Mission Nursing Home. Residents who engage in such behavior in public will be discharged from the facility." Examples of such behavior included assault (including threats of assault). The policy also identified other inappropriate behavior in affecting the health, safety, or welfare of the resident and/or the community would not be allowed. "Residents who engage in such behavior in public and who repeat the behavior twice will be discharged from the facility." Examples of such behavior included self-endangerment. The back side of the policy was titled Informed Consent for Random Search of Room, which residents signed authorizing staff to do random room/surroundings searches whenever there was "reasonable suspicion" of alcohol or drugs present. The policy indicated "Failure to authorize the search can result in immediate discharge planning procedures". The facility's Gazebo Alcohol Program [A program run by the facility, which allows residents to drink a physician approved, set amount of alcohol provided by staff, in a specific area of the building at a specific time each day] Contract, undated, identified in part: 1. Drinking can only be done in the designated area, usually in the barbershop. No drinking is	2 830		

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2 830	Continued From page 16 allowed anywhere else in the building or on the grounds. 2. If you drink alcohol in the building, outside of the gazebo program, alcohol is found in your room or on your person, you will be placed on level 4 (cannot go out of the building without an escort) and you will be restricted from the gazebo as follows: First violation = one week Second violation = two weeks Third violation = off program 3. When you receive or buy alcohol give it to the door monitor. 4. Upon return from any outings, you will be searched for alcohol. 5. There may be a search of your room or person if staff suspects that you are hiding alcohol. 9. If you return from an outing, and you have been drinking alcohol, you cannot go to the gazebo that day. 10. If you fall, get into a fight, are belligerent or aggressive, and/or display any other disruptive behaviors after you go to the gazebo and drink alcohol, you will be put on a 3 day restriction from the gazebo program. Multiple offenses will result in increasing restrictions. 11. If you are caught giving or receiving alcohol to each other you will be restricted from the gazebo for 3 days. 12. You will be breathalyzed before participating in the program that day. Refusal to cooperate with breathalyzer will result in restrictions. 13. If you have to go to detox, hospital, or create a dangerous health situation, your level will change to a level 4 (cannot go out of the building without an escort), and will be restricted from the gazebo for two weeks. An undated facility policy, Resident Monitoring	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 System, identified a leveling system for all residents. The purpose of this system was to keep the residents safe and prevent them from behaviors while out in the community. Classification assessments were conducted at admission and annually thereafter unless there was been a change in condition. The levels were reviewed at each quarterly care conference. Classifications were: Level I: A resident can go out without restrictions. Level II: A resident can sign out and walk around the building for up to half an hour. If the resident does not return within half an hour, the door monitor will go out and find them. The resident could be changed to another more restricted level for failing to follow the limitations of this level. Level III: Residents in this category must remain within eyesight of the door monitor (in the front yard). Level IV: Residents in this category must have an escort at all times when outside the facility. Residents who have had significant behavioral issues or significant cognitive deficits are also in this category. Level V: Residents in this category must stay on their individual floor and cannot go to the other floor without escort. A color coded listing of all resident levels was available at the front door, each nursing station, and with each social worker. Per the policy, all residents sign to acknowledge an understanding of all rules related to the use of alcohol/drugs within the facility and when out on pass. This included the use of alcohol and the privileges available when the rules were followed.	2 830		

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2 830	Continued From page 18 Review of resident records indicated that although these policies were in place, the provider did not consistently use the leveling system, or have any consistent protocol for use or refusal of the breathalyzer, vital sign monitoring, or frequency and length of clinical and safety monitoring for intoxicated residents. R11's quarterly Minimum Data Set (MDS) dated 3/8/16, identified admission to the facility on 3/1/02. It also identified R11 had modified independence with cognitive skills for daily decision making, and demonstrated feeling down, depressed or hopeless. R11 was noted to be independent with activities of daily living (ADLs). Active diagnoses included diabetes mellitus, non-Alzheimer's dementia, anxiety, depression, cognitive communication deficit, alcoholic cirrhosis of liver, and alcohol dependence. The MDS also identified R11 exhibited other behavioral symptoms not directed toward others, and rejection of care. R11's behavioral symptom Care Area Assessment (CAA) dated 7/2/15, identified R11 had episodes of impaired judgment and poor decision making, noting an episode in which he was in a verbally aggressive altercation with another resident which lead to threatening and physical aggression. "He also has been warned about not going out into the community to drink alcohol or take drugs and/or bring anything back in with him." The CAA documentation lacked any direction or guidance in dealing with these behaviors. R11's medical record lacked a comprehensive assessment related to safety of alcohol use. R11's medical record lacked a signed Alcohol and	2 830		

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2 830	Continued From page 19 Drug Use policy. The face sheet identified R11 as his own responsible party. R11's care plan dated 4/8/16, identified a potential alteration in cognition related to alcohol dependence. It also identified a history of going out 'for a few drinks'. Interventions included: encouraging sobriety, Level I monitoring (date initiated 12/11/11), private room due to inability to get along with roommates, and identifying physical and verbal aggression. The care plan also indicated R11 was at moderate risk for falls due to alcohol or drug use. Interventions included: independent with transfers, and observe orthostatic blood pressure monthly. The care plan lacked specific interventions related to alcohol use. The facility provided a Resident Classification Listing by Room dated 4/18/16. R11 was identified as a Level II (which contradicted information provided on the care plan). On 5/16/16, at 10:01 a.m. the social service director (SSD) was asked about the conflicting level information for R11. The SSD stated she was unsure why R11 was a Level II on the Resident Classification Listing. The SSD stated, [R11] "is a Level I, and has been since 9/23/12. Everyone knows this." R11's Fall/Safety Risks Evaluation and Assessment dated 3/7/16, identified no falls in the last 90 days. Additionally, no seizures were noted on the form. The assessment did indicate R11 had a current issue with alcohol and/or drug use, an extensive history of alcoholism, alcoholic cirrhosis of the liver, drunkenness, and alcohol-induced persisting dementia. R11 was identified with no fall risk on this assessment. The	2 830		

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2 830	Continued From page 20 assessment indicated "occasionally resident is confrontational with staff and other residents, especially if drinking alcohol." The Medication Administration Record (MAR) for 4/15, identified a physician's order dated 9/26/13, indicating if R11 went out on the evening shift, he was to do a breathalyzer when he returned. If the breathalyzer was refused, he was to be on 15 minute checks. The order lacked a length of time the 15 minute checks were to continue. Review of R11's progress notes dated 4/22/15 through 5/14/16, identified the following: - 5/4/15, at 10:24 p.m. R11 went for a walk at 6:55 p.m., and returned at 9:10 p.m. Refused breathalyzer, stating, "I'm not on the Gazebo program. I don't have to do that anymore." When interviewed on 5/11/16, at 4:21 p.m. the director of nursing (DON) stated an incident report should have been completed, as well as enhanced monitoring when there was a refusal of the breathalyzer. The DON stated there was no protocol for enhanced or increased monitoring. However, the DON stated R11 should have been on 15 minute checks for refusal of the breathalyzer per his physician order. - 5/23/15, at 3:50 a.m. R11 exited his room, agitated, jumping from one subject to another, at times not making sense, talking about drinking in his room. On 5/11/16, at 4:21 p.m. the DON stated an incident report should have been completed, and a breathalyzer offered, with 15 minute checks if this was refused.	2 830		

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2 830	Continued From page 21 - 5/23/15, at 9:45 a.m. R11 had been speaking to staff in a "foul language". It also noted R11 shared with dietary staff he had been drinking. The documentation included: "In a brief glance around room do not see any alcohol bottles/containers." On 5/11/16, at 4:21 p.m. the DON stated she would expect a breathalyzer to have been offered, with 15 minute checks if refused. The DON also indicated she would have expected an incident report to be completed. - 5/24/15, at 3:30 a.m. identified at 9:50 p.m. R11 was observed blocking the door entrance, with the door monitoring staff outside. R11 began yelling racial slurs to staff and threatening to "physically harm the door monitor." R11 walked toward staff in a threatening manner, swearing, and was informed if he physically harmed staff, the police would be called. R11 went to his room, and returned at 10:05 p.m. cursing, gritting his teeth, and leaning on the nursing station. He was informed the police would be called if he didn't calm down. It was also noted R11's eyes were "extremely blood shot." R11 was checked on x 2 [twice] and appeared to have calmed down. On 5/11/16, at 4:21 p.m. the DON stated a breathalyzer should have been attempted, and 15 minute checks completed if this was refused. She also expected an incident report to have been completed. - 6/17/15, at 12:00 p.m. R11 confronted and had a verbal altercation with a peer, and when being escorted out of the dining room, began to threaten the peer, making the motion of a fist, and attempted to get back in the dining room. The note indicated R11 had slurred speech and	2 830		

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2 830	Continued From page 22 suspected he had been drinking. R11 stated, "Did he laugh at me, I'm gonna knock the shit out of him." A corresponding incident report dated 6/16/15 was completed, but lacked any additional content. On 5/11/16, at 4:21 p.m. the DON stated she would expect a breathalyzer to have been offered, and if refused, 15 minute checks initiated. - 6/17/15, at 5:55 p.m. the SSD and administrator discussed recent behaviors with R11, and he was informed he could not drink in or out of the building unless in the gazebo program. If he gets intoxicated he has to cooperate with the nurses when they ask for a breathalyzer and if he doesn't comply he will be sent to the hospital and/or the police will be called to assist. He stated that he understood and certainly did not want the police called due to his behaviors. Finally he was told that he will be given a notice to discharge if there are any more incidents, he responded with "I am leaving soon anyway" and when asked where he was going he could not give an answer. Administrator reiterated everything one final time and he again said that he understood. A couple of hours later he came up to this writer and said if he was given a discharge notice we would have to find a place for him to go and this writer responded yes. - 6/19/15, at 9:30 a.m. (documented as a late entry) identified R11 was told that he would be given notice to leave if his behaviors continued. - 7/5/15, at 5:36 p.m. R11 had a verbal altercation with a peer, threatening to "beat each other up." Four staff intervened until the peers walked away from each other.	2 830		

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2 830	Continued From page 23 - 7/7/15, at 7:46 p.m. R11 was in a verbal altercation with a peer, entering peer's room, yelling and cursing at peer. - 7/10/15, at 3:12 p.m. R11 complained of abdominal pain, and an abdominal x-ray was ordered. R11 stated, "Don't send them in my room, I'll kill them." -8/20/15, at 1:24 a.m. R11 was complaining about issues to staff. He then began cursing and became agitated. - 9/4/15, at 4:32 p.m. staff reported to nurse R11 appeared to be drunk. The SSD and administrator entered R11's room with the breathalyzer. When asked if he had been drinking last night or this morning, R11 denied it. His speech was somewhat slurred. Breathalyzer read 0.204, and a retest of the breathalyzer was 0.203. "This writer and Administrator then reminded him of a discussion in which he stated that he understood that if an incident like this happened again he would be given a notice to leave. He said that he remembered this. This writer then informed him that a referral would be made for the Glennwood, (wethouse) [a residential facility for chronically alcoholic and homeless men and women], so that discharge planning could begin. He stated understanding of this." On 5/11/16, at 4:21 p.m. the DON stated she would expect 15 minute checks to be completed for refusal of the breathalyzer, and an incident report to be completed. On 5/17/16, at 12:50 p.m. SSD stated R11 was referred to the Glennwood, but he was not accepted there, due to having a colostomy (surgical procedure that brings one end of the	2 830		

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2 830	Continued From page 24 large intestine out through the abdominal wall), despite the fact that R11 is independent in the cares for this. The reason provided was that residents share a bathroom. - 9/8/15, at 10:22 p.m. R11 was found on the floor near the door in his room. He appeared drunk but refused breathalyzer and vital sign assessment. Resident stated "don't call the police I am already in trouble." Corresponding incident report completed, identified plan to "possibly" give resident a 30 day notice to discharge. On 5/11/16, at 4:21 p.m. the DON stated no documentation was available related to 15 minute checks for refusal of the breathalyzer. - 9/9/15, at 5:44 p.m. Staff reported R11 appeared drunk. SSD and another staff entered R11's room. R11 refused breathalyzer. He was informed if he did not do the breathalyzer, "it was the same as saying that he had been drinking." R11 continued to refuse, and closed his eyes. On 5/11/16, at 4:21 p.m. the DON stated R11 refused the breathalyzer, and so she would expect 15 minute checks and an incident report be completed. - 10/19/15, at 6:15 p.m. R11 left facility at 8:30 p.m. and returned at 9:50 p.m. Breathalyzer read 0.105. On 5/11/16, at 4:21 p.m. the DON stated an incident report should have been completed, as well as 15 minute checks. - 10/23/15, at 10:19 p.m. R11 went out from 5:45 p.m. - 9:35 pm. Breathalyzer read 0.162.	2 830		

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2 830	Continued From page 25 On 5/11/16, at 4:21 p.m. the DON stated she would expect an incident report and 15 minute checks to have been completed. - 10/31/15 at 7:15 p.m. R11 had a verbal altercation with housekeeping. A corresponding incident report completed on 10/31/15 lacked any further information. - 11/7/15, at 7:27 p.m. R11 went out at 6:50 p.m., returning at 7:11 p.m. Breathalyzer read 0.022. On 5/11/16, at 4:21 p.m. the DON stated an incident report should have been completed. - 11/9/15, at 9:45 p.m. R11 left at 8:00 p.m., and returned at 8:50 p.m. Breathalyzer read 0.077. On 5/11/16, at 4:21 p.m. the DON stated an incident report should have been completed. - 11/16/15, at 12:30 a.m. R11 to the nurses station asking for medication he had previously refused. He became "very upset and began cursing". Staff attempted to talk with R11, but he refused to listen and walked off to his room. - 11/16/15, at 6:30 p.m. R11 out of the building from 6:30 p.m. - 8:30 p.m. Breathalyzer was 0.08. On 5/11/16, at 4:21 p.m. the DON stated an incident report should have been completed, as well as 15 minute checks. - 11/19/15, at 10:54 p.m. R11 out of the building and breathalyzer read 0.06 upon return. When interviewed on 5/11/16, at 4:21 p.m. the DON stated breathalyzer was below the legal	2 830		

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2 830	Continued From page 26	2 830		

limit, and she wouldn't expect any increased monitoring. The DON stated she was not notified, and would expect herself or the SSD to have been notified of any incident involving drinking of any amount, and would expect an incident report completed.

- 12/24/15, at 5:30 p.m. R11 was found with two cans of beer in his room, observed to be dumping it down the drain when staff entered. R11 began cursing, slammed the cabinet door shut with his foot.

On 5/11/16, at 4:21 p.m. the DON stated no breathalyzer was done. The DON also stated a room search revealed no further alcohol, and she was notified of this incident. There were no further symptoms, and she would not expect 15 minute checks. Further, the DON stated R11 was aggressive, but he was also aggressive without alcohol.

- 3/29/16, at 9:13 p.m. R11 left the facility at 6:20 p.m. and returned at 9:20 p.m. R11 reported being down by the lake, and breathalyzer reading was 0.143.

On 5/11/16, at 4:21 p.m. the DON stated she would expect 15 minute checks and an incident report to have been completed.

- 4/13/16, at 9:06 p.m. R11 left the building and refused breathalyzer upon return.

On 5/11/16, at 4:21 p.m. the DON stated she would expect an incident report be completed as well as 15 minute checks for refusal of the breathalyzer.

- 5/7/16, at 6:40 p.m. R11 left the facility at 2:05

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2 830	Continued From page 27 p.m. and returned at 6:39 p.m. Breathalyzer read 0.256. Resident went to his room. On 5/11/16, at 4:21 p.m. the SSD stated R11 was not on the Gazebo program because he didn't want to follow the rules, and it was his right to drink. The DON also verified that on 5/7/16 when R11's breathalyzer reading was so high, R11 had gone to his room. The DON was unable to provide any documented assessment at that time such as vital sign readings, or increased clinical and safety monitoring having been done. The DON stated she would have expected an incident report and 15 minute checks to have been completed. R11's Social Services Review notes dated 3/10/16, identified "He does display some short term memory deficits some of which could be selective memory. He has episodes of impaired judgement." The notes also included, "He can also be verbally aggressive towards staff especially when they want him to do something. He does not want anyone in his room even after knocking. He has episodes of drinking inside or outside of the building and then denying that he has. Social Service will remain actively involved through 1 to 1 visits and behavior management interventions as needed." During observations on 5/11/16, at 2:25 p.m., 5/13/16, at 10:41 a.m., 5/15/16, at 11:44 a.m., 5/16/16, at 1:10 p.m., and 5/16/16, at 3:00 p.m., R11 was asleep in bed, and did not reply when spoken to. On 5/11/16, at 6:55 a.m. the DON reiterated that if a resident returned intoxicated, she would expect a nursing assessment to be completed, and with a breathalyzer reading of 0.256, she	2 830		

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2 830	Continued From page 28 would expect increased monitoring to be done. She also stated R11 had a history of coming back to the facility intoxicated, but was unable to find any documentation of increased monitoring done for any of the incidents when R11 returned with signs and symptoms of intoxication and refused a breathalyzer. R51's quarterly MDS dated 4/28/16, identified the resident had modified independence in cognitive skills for daily decision making, behavioral symptoms not directed toward others, and required the use of a wheelchair. Diagnoses included hypertension, diabetes mellitus, seizure disorder/epilepsy, and depression. R51's CAA dated 11/3/15, identified diagnoses of acute alcohol intoxication/withdrawal, physical weakness, depression, limited range of motion, poor coordination, poor balance, and visual impairment. It also identified behavior problems including disruptive, loud talking in the dining room "especially after Gazebo/alcohol program." The CAA noted impaired balance during transitions, and difficulty maintaining sitting balance as well as agitation and decreased mobility. The CAA lacked any direction or guidance in dealing with these behaviors. R51 did not have a comprehensive assessment related to the safe use of alcohol. R51's medical record included a signed contract to participate in the Gazebo program dated 8/7/15. However, there was not a signed Alcohol and Drug Use policy. The face sheet identified R51 as his own responsible party. R51's care plan dated 4/27/16, identified a self care performance deficit related to alcohol use. It also identified R51 had a potential risk for falls	2 830		

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2 830	Continued From page 29 related to being wheelchair bound, and the use of alcohol with the Gazebo program. The plan of care indicated both long and short term memory problems, and poor judgement and decision making due to alcohol dependence. The care plan also identified an alteration in mood and behavior related to acute alcohol intoxication/withdrawal. Interventions included to remind of the rules around the gazebo/ alcohol program. The care plan failed to identify R51's alcohol monitoring level. The Resident Classification Listing By Room form, dated 4/18/16, identified R51 as a Level III. Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following: A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility." - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo program. "Client monitored closely". Blood pressure upon waking is 75/54 and heart rate 75. Given meal tray and drank 300 ml (milliliters) of water. Blood pressure at 6:30 p.m. 87/53. Physician notified and orders received to check blood pressure every four hours and continue to encourage fluids. Other notes from this date identified resident left at 10:35 a.m. with his niece and returned at 1:05 p.m. He was searched and breathalyzer was 0.258. Staff found a bottle of whiskey in his room, which was locked in the liquor cabinet. An incident report was completed for this incident on 7/1/15, noting "Resident was	2 830		

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2 830	Continued From page 30 instructed to not drink." The record lacked evidence their Gazebo policy was followed. On 5/11/16, at 3:02 p.m. the SSD stated, "if they mess up like this when in the program, they would be suspended for 3 days, or a week if they are sent to the hospital or detox." - On 7/2/15, at 10:48 a.m. a note indicated R51 had been seen by the nurse practitioner, and the note indicated R51 is an adult and can drink and smoke when he wants. "He is not hurting himself or anyone else." - On 7/2/15, at 1:59 p.m. a note identified R51 was on a three day suspension from the Gazebo program. A Physician Progress note for R51 dated 7/2/15, identified the chief complaint as alcohol intoxication. It noted resident had a breathalyzer reading of 0.258, and blood pressure was noted to be low at 87/56, with a retake at 75/54. The note indicated during interview with the physician the resident had stated, "I am fine, I went out with someone and had some drinks. I am an adult and I will do whatever I want. I am here because I can drink and smoke. If I get the opportunity again, I will do it. I am not hurting myself or anyone else when I drink, so I should be left alone." The nursing progress notes indicated R51 was allowed to sleep it off, there was no report of aggressive behavior towards staff and included, "Patient will be off Gazebo program for three days. Nursing will continue to monitor for any sign of withdrawal." - On 7/8/15, at 1:20 p.m. the notes indicated R51 was restricted from the gazebo program due to having the bottle.	2 830		

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2 830	Continued From page 31 - On 8/6/15, at 10:11 p.m. notes indicated the resident had left with his niece at 2:15 p.m. and returned at 3:45 p.m., appearing drunk and very talkative. "Social worker notified, and resident will be monitored." It was also documented R51 had refused the breathalyzer as well as other assessments. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m. the DON stated enhanced monitoring should have been completed as well as an incident report for these incidents. - 8/17/15, at 3:51 p.m. resident left after the Gazebo program in a taxi at approximately 3:13 p.m., attempting to take a peer with him. The documentation indicated the SSD had attempted to stop the resident, but he'd left anyway and had returned at approximately 3:46 p.m. with a brown paper bag, and a bottle of alcohol in it. The notes indicated staff had taken the bag, and the resident was verbally abusive toward staff. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m. the DON stated the alcohol was taken from R54 and locked up in a cabinet. A Code B (a behavior that cannot be controlled, where all available staff come to help) was called since R54 was following the staff and threatening her. When the nurse went in, R54 was intoxicated, slurring his words. Breathalyzer at this time was 0.336, and his blood pressure was running low. The on call physician was called, and instructed staff to monitor resident, encourage fluids, and to call back if there was a decline. DON stated the blood pressure was stable later. Further, DON stated there is not	2 830		

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2 830	Continued From page 32 policy or procedure to follow and the physician does not specify a frequency of the checks. - On 8/17/15, at 11:10 p.m. noted resident was examined by a registered nurse in his room at approximately 7:25 p.m. He was "clearly intoxicated, fatigued, and slurring his words." Breathalyzer was 0.336. Blood pressure 94/59 and 86/54. Physician notified and orders received to monitor resident and encourage fluids. Call back with a decline. At 10:00 p.m. blood pressure was 146/82. Also noted at this time to be more awake, not slurring words, and drinking fluids. The record lacked evidence the Gazebo policy was followed. On 5/11/16, at 3:02 p.m., the DON stated the only documentation of checks was in the note from the nurse which indicated R54 was checked on every 1-2 hours. She would expect that an incident report and increased monitoring were completed. - On 8/18/15, at 2:57 a.m. noted at approximately 12:15 a.m. staff attempted to obtain vital signs, and resident was increasingly agitated, using foul language. Noted staff obtaining frequent checks on resident every one to two hours for safety. A Physician Progress Note dated 8/21/15, identified a review of the incident [dated 8/17/15] where resident returned to the facility and had a breathalyzer of 0.33. The note indicated the vital signs were now normal and resident is back to his baseline. During interview with the physician, R51 stated he was "angry that the social worker can not allow him to bring his own 'Booze' into the facility. He was also angry that he will be off the Gazebo program for 3 days since he got himself intoxicated." The progress note identified no education and no orders were provided for	2 830		

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2 830	Continued From page 33	2 830		

increased monitoring when R51 was intoxicated. Then note indicated nursing was to continue to monitor for any signs or symptoms of withdrawal.

- On 9/28/15, at 10:36 p.m. resident returned to the facility via taxi at approximately 6:00 p.m. and was met at the door by SSD. He turned in his alcohol bottles, and breathalyzer was 0.141. Resident was informed by SSD that he will not be attending Gazebo tomorrow.

On 5/11/16, at 3:02 p.m., the SSD stated R51 liked to go out and drink with his meals. She verified the Gazebo policy identified that drinking outside the program would result in a one week suspension, which had not been enforced in this case. At that time, the DON also stated, "we are assuming that he is going to go out and drinking." The DON stated there was no assessment available to use for residents consuming alcohol. She indicated an incident report and increased monitoring should have been initiated.

- On 10/24/15, at 1:33 p.m. notes indicated R51 had refused to shower the evening before, and had been informed he could not attend the Gazebo program, so had become very upset and angry.

- On 11/5/15, at 11:24 p.m. identified R51 had returned at 5:35 p.m. from going out on a visit with his brother [left at 12:05 p.m.] The note indicated he was drunk and went to his room after being searched. The record lacked evidence the Gazebo policy having been implemented.

On 5/11/16, at 3:02 p.m. the DON stated an incident report should have been completed, a breathalyzer offered, and enhanced monitoring completed. At that time the SSD also stated there

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2 830	Continued From page 34 should have been a restriction for not following the gazebo contract. - On 12/4/15, at 10:26 p.m. the notes indicated R51 had gone out at 12:05 p.m. At approximately 6:00 p.m. a call had been received about the resident being drunk at a local liquor store, and being under supervision of the police. R51 had been sent to the hospital. The hospital visit note dated 12/4/15, indicated R51 had arrived via ambulance. "Report that patient was outside a liquor store in Plymouth with intoxication. Police were called. Arrives with appearance of intoxication and slurring words. Patient is wheelchair bound. Reportedly lives at Mission detox center." Further information included, "Patient was conversing in room when he had loss of consciousness on the cart lasting about 30 seconds. Patient unresponsive to sternal rub. Came to after 30 seconds and started yelling incoherently." The last note from this visit identified "Pt [patient] increasing agitation; numerous requests for his belongings and to be allowed to leave. MD [physician] in room speaking with pt." On 5/11/16, at 3:02 p.m. the DON stated dispatch had called the facility regarding the 12/4/15 incident. The SSD also stated R51 had gone out to eat, and the restaurant was across from a liquor store. The SSD stated R51 had left the restaurant and gone to the liquor store. Staff at the liquor store had subsequently called the police, reporting someone intoxicated. The SSD stated the facility did not have a copy of the police report. The DON stated she'd instructed dispatch to take R51 to the hospital for evaluation. Upon return to the facility after six hours, R51 had refused the breathalyzer or vital signs. The DON said R51 had been demanding staff call the	2 830		

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2 830	Continued From page 35 police and hospital to return his alcohol. Staff had calmed him down and R51 returned to his room. The DON stated no alcohol levels or reports were available from the hospital. There was no record if a physician was contacted for any orders of increased monitoring. The DON confirmed her expectation that increased monitoring would be completed as well as an incident report. The DON also stated R54 had posted a note on his door stating he was not to be disturbed unless it was for the gazebo. The SSD stated R51 had to eat lunch, or he would not be able to attend the gazebo program and added, "He is taking it more serious lately because it is important to him." - On 12/5/15, at 1:47 p.m. documentation indicated R51 had not been allowed to attend the Gazebo for breaking rules yesterday [12/4/15] (drinking alcohol outside the Gazebo program). Another note on the same date at 1:47 a.m. indicated R51 was requesting staff call the ambulance company and the police as they had taken his bottle of alcohol. The notes indicated R51 had become agitated, and was arguing. An additional note at 1:05 a.m. identified R51 returned to the facility via ambulance, demanding and rude with increased agitation. R51 refused a breathalyzer, eyes were blood shot, and he was slurring his words. - On 12/5/15, at 6:49 p.m. notes indicated R51 had not been allowed to attend the Gazebo program until re-evaluated after the weekend. When interviewed on 5/11/16, at 3:02 p.m. the DON stated an incident report should have been completed, as well as increased monitoring. The SSD also stated at that time that R51 had been restricted from the Gazebo program for one day, which she verified did not correlate with the	2 830		

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2 830	Continued From page 36 Gazebo Alcohol Program Contract which directed a one week violation for drinking outside of the gazebo program. A Psychology Progress Note dated 2/16/16, identified R51 had been treated for depressed mood and alcohol use disorder. "Patient is now want [sic?] to control drinking program. He has not had any acute binge episodes that I am aware of recently." Previous visit with psychology was dated 11/17/15. - On 1/10/16, at 1:44 p.m. notes indicated R51 quickly returned from the Gazebo program after receiving ice from staff. There was a covered coffee cup noted behind the resident. R51 was asked if staff could check the cup, and after R51 stated "yes" it was noted to smell of alcohol. The cup was taken, and the resident chased staff around the front lobby. The note indicated the SSD had been notified and R51 was restricted from the Gazebo the following day for breaking rules. The record lacked evidence the Gazebo policy was followed, which directed a one week violation for drinking outside of the Gazebo program. - On 2/3/16, at 4:53 p.m. R51's quarterly note identified when he participated in programs after the gazebo program, he was noted to be talking inappropriately/making sexual comments. - On 2/29/16, at 7:32 a.m. R51 refused to have a Keppra level drawn, and became verbally aggressive with the phlebotomist. The notes indicated R51 had come to nursing station later, stomping his feet and yelling he did not want to be awakened for anything but the Gazebo program.	2 830		

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2 830	Continued From page 37 A Physician note dated 4/12/16, indicated, "Patient taking Keppra, refused keppra level draw on request. Nursing will attempt again to draw keppra level next lab day. No report of seizures since admission to the facility." On 5/11/16, at 3:02 p.m. the SSD stated R51 had a history of only wanting to be awakened for the Gazebo program, stating he'd been informed he needed to eat lunch before attending the program, and had been compliant with this. The SSD stated there had been no restriction from the gazebo program for refusing therapy/services, or from behaviors of yelling at staff when they enter his room to offer services. - On 3/13/16, 12:19 p.m. notes indicated R51 had been yelling at staff in his room for waking him to administer insulin, and had stated the sign on his door indicated to never wake him except for the gazebo program. - On 3/13/16, at 9:41 p.m. notes indicated R51 had again stated staff should only wake him for the Gazebo program. - On 3/14/16, at 2:49 a.m. resident was noted to be offered insulin prior to lunch. The notes indicated R51 had stated, "NO...DO NOT EVER WAKE ME...ONLY WAKE ME FOR GAZEBO." A physician's note dated 4/12/16, identified "Random blood glucose high from 112 to 298 since beginning of February till date, has been higher in the 300s in the past months. HgbA1c (a blood test that provides information about a person ' s average levels of blood glucose, also called blood sugar, over the past 3 months) high at 9.4 as at 1/11/16, was 7.7 in October 2015. Has gone 2 point higher than before." The note	2 830		

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2 830	Continued From page 38 also indicated, "Patient was started on Latus [sik] in Feb [February] 2016, random blood glucose ranging from 132-180 since the beginning of April. No report of hypoglycemia, seizure from nursing. Patient reported to be refusing blood draws and finger sticks at times." - On 3/31/16, at 5:45 p.m. Therapy discontinued for gait training due to resident either refusing or attempting to be seen after the gazebo program. - On 4/12/16, at 3:00 a.m. R51 was informed of an emergent call from his son. R51 stated "I do not care if it is an emergency. I only want to be woke up for GAZEBO." - On 5/6/16, at 8:55 p.m. R51 requested to never be awakened for anything but the Gazebo. On 5/10/16, at 12:17 p.m. the DON stated no assessments had been completed on residents related to alcohol use unless they are a part of the gazebo program. The DON stated, "Residents cannot drink at the facility unless they are a part of this program, and should not be going out and drinking. If they come back intoxicated, staff are expected to ask if a breathalyzer can be performed. If this is refused, nursing should be checking vital signs, and monitor them through the night. If the resident is a danger and not medically stable, they should be sent to detox. The physician should be notified of anyone drinking." The DON stated there was no specific policy about when results of the breathalyzer level should be reported to the physician but stated, "If a person is on the gazebo program and goes out drinking, they are off the program for a specific amount of time. After that, the SSD and administrator handle the resident, since they are in violation of the policies at the	2 830		

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2 830	Continued From page 39	2 830		

facility." The DON also stated she would expect that all incidents involving alcohol and breathalyzers be reported to her.

On 5/13/16, at 10:44 a.m. R51 stated he had been at the facility for about a year and a half, and had been part of the Gazebo program ever since. He agreed to come to this nursing home "because I was able to drink and smoke." R51 stated he signed a contract for the program, but was not exactly sure what it specified. "I didn't read it thoroughly. I had to sign to participate." Further, R51 stated the alcohol was purchased by the SSD, and it was locked up. "I have been restricted on one or two occasions, when I drank more than I should have." R51 stated when he was hospitalized, he had only been restricted for 1-2 days. "I don't drink on outings anymore. I have nobody locally to take me on outings. I would if I could." The facility knows if I go out "I am probably gonna drink. I'm not driving."

When interviewed on 5/17/16, at 8:26 a.m. the consultant registered pharmacist (RP) stated it would not be recommended to use alcohol while taking Keppra, due to the sedation and the side effect of sedation when alcohol and Keppra were used together. The MD had addressed the need for the medication. The RP also stated the facility had not informed her of the alcohol use by the residents, except that R51 was in the Gazebo program.

R54's annual MDS dated 12/19/15, identified medical diagnoses which included a seizure disorder and depression, with no memory impairment.

R54's Social Services Review dated 12/14/15, indicated R54 had a history of significantly

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2 830	Continued From page 40 impaired judgement secondary to alcohol dependence. The review identified R54 had no alcohol related problems and had not displayed any significant behaviors. The review included social services would continue with active interventions including 1:1 visits and discharge planning as needed. R54's CAA for psychotropic drugs dated 12/19/15, identified R54 received Keppra (medication to control seizures) daily for a history of seizures, which were alcohol induced and currently there was no alcohol use. R54's quarterly MDS dated 3/10/16, identified R54 made poor decisions and cues and/or supervision was required. The MDS identified R54 had verbal and other behaviors, however failed to address if the behaviors put himself or others at risk for injury. The MDS also identified R54 was independent with activities of daily living (ADL's) and had one fall without injury since admission. R54's medical record lacked a comprehensive assessment related alcohol use. R54's care plan dated 3/16/16, identified R54 was at high risk for falls related to alcohol use and had a history of falls prior to admission as well as a fall on 3/3/16, related to suspected drinking. Interventions included staff to observe the whereabouts and safety of the resident when he is sitting outside. The care plan also addressed R54's alcohol abuse and that R54 will go out and may drink which could alter his ability with ADL's. The interventions listed did not address what staff should do if his ADL's were altered do to drinking. The care plan also addressed R54 was independent in bed mobility, transfers and	2 830		

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2 830	Continued From page 41 ambulation with a four wheeled walker throughout the facility and outside. Interventions included R54 to be independent with ambulation with the walker throughout the facility and outside. The care plan dated 4/8/16, identified an alteration in behavior and mood with episodes of drinking either at the facility or outside the facility and then denying he did it, with refusals to comply with discharge planning. Interventions listed included 1:1 visits to discuss concerns and develop positive solutions and refer to psychologist as needed for mood concerns. The care plan failed to identify safety interventions for R54. R54's nurse practitioner (NP) note dated 3/4/16, identified R54 had lifelong/ current alcohol abuse, and noted R54 denied he will drink any longer. Staff to monitor. R54's medical record lacked any daily tracking for behaviors and/ or alcohol use. R54's NP note dated 4/11/16, identified staff smelled alcohol after patient returned from outings, and that he left in a cab daily. The note also identified that R54 had falls without injury and had refused breathalyzer testing. The NP indicated he was receiving a 30 day notice soon and noted, that due to his chronic alcoholism it may be necessary to find him housing where drinking is allowed and monitored. R54's medical record lacked a signed Alcohol and Drug Use policy R54's Order Summary Report, last reviewed on 5/9/16, included diagnoses of alcohol dependence and major depressive disorder. The undated nursing assistant sheet, directed	2 830		

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2 830	Continued From page 42 staff to observe for drinking and alert the nurse if there was alcohol on R54's breath. The Resident Classification Listing By Room dated 4/18/16, indicated R54 was a Level 1 and needed to be searched upon return to the facility. The information was not included on R54's care plan. A progress note dated 12/13/16, identified R54 had a history of alcohol abuse. A progress note dated 2/10/16, indicated a staff member reported that she thought R54 had been drinking. R54 denied he had been drinking. A search of his room was conducted and no alcohol was found. A breathalyzer was administered and the the resident's reading was 0.177. R54 was informed that since he was not acting drunk or having behaviors he would not need to go to detox this time. The documentation lacked any monitoring or follow up of R54's condition. On 5/11/16, at 3:52 p.m. the SSD stated R54 was at the facility short term doing therapy, and staff "don't want him to drink. He is another one that when he says he goes out will drink." The SSD stated bags were to be searched upon his return. Further, SSD stated they are working on finding R54 an alternate placement, and the insurance company was working with him on this. The DON stated R54 fell when he drinks, and has a significant alcohol use history. The DON also stated it would not be advised for R54 to drink while taking Keppra. The DON stated no documentation was available on increased monitoring and no incident report had been completed. The facility's incident log identified R54 had the	2 830		

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2 830	Continued From page 43 following alcohol related incidents: - 3/3/16, at 11:15 p.m. R54 was found on the floor by the entryway to the room and a alcohol bottle was found. On 5/11/16, at 3:52 p.m. the DON stated no breathalyzer was completed. Vital signs were checked with the neuro assessment. "He is at risk for falls when he is drinking." R54 sustained a skin tear on his right elbow from the fall. - 4/8/16, at 9:49 p.m. R54 fell in his room. Resident smelled like he had been drinking alcohol, denies drinking and refused to do breathalyzer. DON notified. Three full Gatorade bottles at bedside. Vital sign checks done with the neurological assessment. On 5/11/16, at 3:52 p.m. the DON stated increased monitoring was completed. The SSD stated if a 30 day notice was provided, the administrator would be informed and the interdisciplinary team (IDT) would discuss it. She also stated R54 was "hooked up with the Medicare coordinator. The county does the relocation thing and they help him look at places." The SSD stated she talked with the county and discussed placement options, and stated "I believe his last day is the 14th [5/14/16]". - 4/11/16, at 7:50 p.m. R54 fell in room trying to go to bed, smelled of alcohol. - 4/23/16, at 3:45 p.m. R54 found on the floor and smelled of alcohol. On 5/11/16, at 3:52 p.m. the DON stated she would expect staff to call the physician, do an incident report, and notify the administrator. R54	2 830		

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2 830	Continued From page 44	2 830		

was considered a high fall risk when he was drinking. The SSD stated "We have AA (alcoholics anonymous) that comes here, but these guys are not going to do that."

R54's Comprehensive Fall Report Form dated 3/3/16, identified R54 was found on the floor on his back in the entry area of his room. The form identified R54 smelled of alcohol and an empty bottle of vodka was found on the floor. R54 was unable to do a breathalyzer as the resident could not blow into the device correctly. R54 sustained a 1/2 centimeter abrasion to his right elbow. R54's blood pressure was 98/50 with a pulse of 79, neuro checks were initiated due to an unwitnessed fall. Immediate interventions included increased level of observation, call light in reach and no more alcohol tonight. The investigation section identified that R54 appeared to have been consuming alcohol. The final analysis and plan included re-education on the alcohol policy of the facility. The corresponding IDT Review progress note dated 3/7/16, indicated R54 was re- educated on alcohol policies. No other interventions were identified to assist with ensuring R54's safety with the use of alcohol.

R54's Social Service Review dated 3/11/16, indicated R54 had some short term memory deficits, especially after drinking along with some episodes of impaired judgement. The review also identified throughout the quarter R54 had episodes of drinking either out of the facility and coming back or "somehow" was sneaking it back into the facility and drinking in his room. There was no evidence an investigation was completed to identify how R54 was accessing alcohol.

A progress note dated 4/8/16 at 9:49 p.m. identified R54 had fallen and was found on his

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2 830	Continued From page 45 back. No injuries were noted and R54 denied pain. R54's pupils were dilated and smelled like he was drinking alcohol. R54 denied drinking alcohol and refused to do a breathalyzer. Neuro checks were started, blood pressure running low and director of nursing notified. Initial blood pressure 128/72 and pulse 87. Blood pressure 94/56 and pulse 88 at 9:35 p.m. The facility did not provide the corresponding Comprehensive Fall Report Form for this incident. A progress note on 4/9/16, indicated R54 continued to smell of alcohol and had three full Gatorade bottles at the bedside. The corresponding IDT progress note dated 4/11/16, indicated R54 was re-educated on alcohol policy, with active discharge planning. No other interventions to assist with ensuring R54's safety when drinking alcohol. R54's Monthly Nursing Assessment dated 4/19/16, indicated R54 had been drinking alcohol within the last month and was not a member of the gazebo program. The assessment also identified that R54 had a history of falling while drinking and refused a breathalyzer when he smelled of alcohol. R54's Comprehensive Fall Report Form dated 4/23/16, identified R54 was found on the floor near his bed and he smelled like he had been drinking. R54 was not injured. His blood pressure was 116/65 with a pulse of 75. Immediate interventions included increased level of supervision, call light in reach and encourage resident to keep walker within reach. The investigation section identified all falls to this point resident has smelled of alcohol and refuses a breathalyzer. The final analysis and plan included continue to search resident upon returns to the building and remind again of alcohol policy. The	2 830		

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2 830	Continued From page 46	2 830		

corresponding progress note dated 4/23/16, identified that R54 smelled of alcohol and refused a breathalyzer test and neuro checks were started due to unwitnessed fall. The corresponding IDT review progress note dated 4/25/16, indicated staff were to continue to search R54 for alcohol and remind him of the alcohol policy. There were no interventions identified to assist with R54's safety related to his alcohol consumption.

R54's Fall/Safety Risk Evaluation and Assessment dated 3/10/16, indicated the most recent fall for R54 was 3/3/16. R54 was assessed to be a high fall risk due to a recent alcohol consumption resulting in a fall without injury and the alcohol policy and procedures were reviewed with the resident. No other interventions to ensure R54's safety were identified.

On 5/11/16, at 2:22 p.m. R54 was observed to be sleeping in his room. R54 was dressed appropriately with a four wheeled walker at the bedside.

On 5/11/16, at 2:10 p.m. the resident monitor (RM)-A stated that there were residents identified that needed their bags checked upon return to the facility. RM-A stated he searched their bags but did not "frisk" the residents. If alcohol was found on the residents we let the charge nurse know. RM-A further stated that he looked for residents stumbling or smelling of alcohol. R54 was on the list to be searched upon return to the facility, but RM-A had never found alcohol on him.

When interviewed on 5/16/16, at 1:09 p.m. R54 stated he occasionally had some drinks, but can not drink at the facility because he was not part of the gazebo club. R54 denied drinking, however

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2 830	Continued From page 47 stated the nurses have asked him to do a breathalyzer when he returned to the facility, without explaining why. R54 further stated none of the facility staff members have ever asked him about his drinking history or whether he wanted to continue drinking. R54 continued to explain that he had problems with drinking in the past, more than socially, just for something to do. On 5/10/16, at 3:38 p.m. trained medication assistant (TMA)-B explained the gazebo program. TMA-B stated the social worker did an assessment before residents could join the program. The resident had to agree to the rules of the program and if approved could participate in the program on a daily basis. Everyday prior to participating in the program the resident came to the nursing station and took a breathalyzer if it showed they haven't been drinking they can participate in the program. After the program the residents that participated have an assessment to see if they can count backward from ten. R51 was part of the gazebo program, however TMA-B had seen R51 intoxicated after returning to the facility from a pass for the day with friends or family. TMA-B stated that she had seen this two to three times and he often refused a breathalyzer when he came back. When R51 refused a breathalyzer his medications were held and he was sent to bed to sleep it off. For "punishment R51 could not participate in the gazebo program for a week, but sometimes the punishment is only three days, it varies." TMA-B stated that if a resident was intoxicated vital signs should be checked for twenty-four hours and complete checks every fifteen minutes for a time. TMA-B further stated sometimes R51 refused. The front desk was supposed to check for alcohol when residents return from leave.	2 830		

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2 830	Continued From page 48 On 5/12/16, at 10:41 a.m. TMA-C stated R51 smelled like alcohol, but alcohol hasn't been found on him. On 5/12/16, at 10:46 a.m. NA-O stated that R11 came back to the facility and had been drinking. NA-O also stated that R11 had snuck alcohol back into the facility. NA-O stated it happened one to two times per month. NA-O stated in the past residents used to be sent to detox when they had been drinking, but the facility doesn't do that anymore. NA-O stated R51 drank with the gazebo program but had been known to drink outside of the program as well. On 5/11/16, from 3:02 p.m. to 5:02 p.m. the DON, SSD, and administrator were interviewed together. The SSD stated that generally speaking if a resident was intoxicated, vital signs were done and the resident was asked to lay down. The DON stated the resident should be closely monitored by checking on them frequently. The DON did not define frequently. The administrator indicated the frequency would be at the nurse's discretion, and confirmed frequent monitoring had not been completed for these documented incidences of alcohol use. The administrator further verified after discussing the issues of compliance related to the residents on the Gazebo program, and the residents drinking while out of the facility, that the facility's documentation was lacking assessment and consequences of non-compliance. The adminsitrator stated there needed to be more documentation and that he was unaware of the extent of the drinking at the facility until they'd started talking with staff for education after the IJ was called. The DON stated all residents on the first floor have the potential to go out of the facility and come back intoxicated, but not all residents have the motivation to do so.	2 830		

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2 830	Continued From page 49 The DON also stated that she or the SSD were to be notified of any incidents involving alcohol, including the amount of alcohol, and an incident report should be completed. She indicated the facility needed a plan, so there was consistency among the nurses. The SSD stated, "It needs attention, as we do have concerns for their safety." On 5/16/16, at 1:37 p.m. the SSD stated there was no documentation for any level changes with R51 or R54. No specific written assessment was completed to determine levels, just an informal assessment with the IDT. The SSD said the IDT included social service and nursing, and sometimes a therapy staff if the resident was in therapy. "We look at behaviors and cognition and see how they are doing with both of these. Any changes would be made on the level sheet." The SSD verified being responsible for making any changes to the care plan regarding the levels. "The residents are expected to sign out when they leave the building on a sheet with the resident monitors at the front door. Residents are allowed to leave the building based on their level privileges, which determines their safety level when leaving the building. However, there is no official assessment to determine the levels." When interviewed on 5/17/16, at 12:50 p.m. the social services director (SSD) stated part of her role with chemically dependent residents is determining their history. The SSD stated during the initial care conference, she lets the interdisciplinary treatment team (IDT) know what is appropriate for the individual resident. The SSD acknowledged if residents drink "too much" they could be a danger to themselves or others, but was unable to state what "too much" was, but stated definitely if they get alcohol poisoning, or if	2 830		

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2 830	Continued From page 50 R51 would have a seizure, that would be too much. The IJ that began on 5/12/16, was removed on 5/17/16, when the facility ensured assessments for alcohol use and safety had been completed, care plans for the identified residents had been updated, policies had been revised and/or developed, an intoxication/impairment assessment tool was developed, and it could be verified by interview that staff had been educated regarding these interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff and monitor to ensure all residents were assessed for safety related to alcohol intoxication including receiving appropriate nursing care and treatment. The DON could educate all staff on these systems. The DON or designee could report the findings to the Quality Assurance Committee and complete audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed. This MN Requirement is not met as evidenced	2 850		

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2 850	Continued From page 51 by: Based on observation, interview, and document review, the facility failed to provide daily assistance with shaving for 1 of 3 residents (R 38) who required assistance with activities of daily living. Findings include: R38 was admitted to the facility on 5/21/15. R38's quarterly minimum data set (MDS), dated 2/16/16, identified R35 had moderate cognitive impairment. Further more, R38's MDS identified him as having Alzheimer's Disease, receiving hospice care, and requiring extensive physical assistance with personal hygiene. R38's care plan, dated 4/26/16, identified him as having a self care deficit in ADL's requiring one staff to assist with grooming. R38's care plan further specified for staff to "Encourage to wash his face and hands." The care plan did not specify any preferences in the cares provided with grooming. R38's face sheet included an admission photo in which R38 had a thick white and gray mustache. On 5/9/16, at 7:00 p.m., R38 was observed sitting in his wheelchair. White hairs, approximately 1/8" (inch) long, were noted on his upper lip and scattered on both cheeks. On 5/10/16, at 11:33 a.m., R38 was observed with the same white hairs on his upper lip and scattered on both cheeks. The stubble was approximately the same as the day before. On 5/11/16 at 8:24 a.m., family member (FA)-1 had concerns that R38 was not being shaved	2 850		

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2 850	Continued From page 52 often enough. FA-1 further thought that R38 was only receiving assistance with shaving once a week. FA-1 stated that shaving was very important to R38, who had been "the most particular person you can imagine" regarding shaving. FA-1 went on to state that shaving "was a huge thing for him." FA-1 stated R38 always kept his mustache in his younger years and would "not feel good" about the mustache being shaved. On 5/11/16, at 7:14 a.m., R38 was again observed sitting in his wheelchair, waiting by a medication cart. R38 continued to have white facial hair on his upper lip and cheeks. The hair on R38's upper lip and cheeks was longer than when observed on 5/9/16. On 5/12/16, at 7:43 a.m., R38 was observed sitting in wheelchair eating breakfast in the dining room. His hair appear wet and had been combed. R38 stated he had had a bath that morning. The white hair on his upper lip and cheeks was now approximately 1/4" long. On 5/13/16, at 10:10 a.m., nursing assistant (NA)-M stated that R38 received grooming, bathing, and shaving assistance from the hospice aides and the facility nursing assistants. NA-M stated shaving was the responsibility of the facility nursing assistants, not hospice. NA-M stated R38 had his own razor and there was a floor razor for resident use as well. NA-M stated R38 never refused offers to shave and NA-M shaved him that morning. Later that same day at 11:29 a.m., R38 was observed sitting in his wheelchair looking out the window. His face was clean shaven, including the hair on his upper lip. On 5/13/16, at 1:39 a.m., licensed practical nurse (LPN)-B stated R38 was shaved by both hospice	2 850		

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2 850	Continued From page 53 and facility staff and went on to state that most residents were shaved every third day. LPN-B stated nursing staff would shave a resident if they needed it because they would "see it [facial hair]." LPN-B further stated residents' care plans identified how often they needed to shaved or groomed. LPN-B verified nursing staff charted shaving with morning cares and documented on cares under the facility document entitled "ADL (activities of daily living) Care Provided." LPN-B explained if the documentation reported shaving had not been done, then R38 was not shaved that day. On 5/16/16, at 10:38 a.m., LPN-A stated shaving was suppose to be a daily event and was included in "grooming." LPN-A stated the facility was having trouble finding electric razors at one time and thought some nursing staff did not know how to use non electric razors. LPN-A further stated she would assume nursing staff would know that shaving is part of grooming but has had to remind staff. LPN-A was unaware of where nursing assistants charted grooming cares. ADL Care Provided sheets were reviewed from 5/11/16 to 5/16/16. Documentation identified that R38 was shaved once on 5/15/16 with extensive assistance. All other documentation under "shaving" between that period of time identified the "activity did not occur." ADL Care Provided care sheets were requested for the previous three months. None were provided. R38's care plan, dated 4/26/16, identified him as having a self care deficit in ADL's requiring one staff to assist with grooming. R38's care plan further specified for staff to "Encourage to wash his face and hands." The care plan did not specify the frequency or cares provided with grooming.	2 850		

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MISSION NURSING HOME	3401 EAST MEDICINE LAKE BOULEVARD PLYMOUTH, MN 55441

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2 850	Continued From page 54 A facility policy entitled Resident Cares Grooming, last reviewed 4/20/06, directed staff to "Assist or supervise each resident with shaving on a daily basis." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review systems for resident ADL's. The DON or designee could in-service all staff on performing activities of daily living (such as shaving) for residents. The DON or designee could monitor for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to assess preference of facial hair for 1 of 2 residents (R38) reviewed for choices. Findings include: R38 was admitted to the facility on 5/21/15. R38's quarterly minimum data set (MDS), dated 2/16/16, identified R35 had moderate cognitive	2 920		

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2 920	Continued From page 55 impairment. Further more, R38's MDS identified him as having Alzheimer's Disease, receiving hospice care, and requiring extensive physical assistance with personal hygiene. R38's care plan, dated 4/26/16, identified him as having a self care deficit in ADL's requiring one staff to assist with grooming. R38's care plan further specified for staff to "Encourage to wash his face and hands." The care plan did not specify any preferences in the cares provided with grooming. R38's face sheet included an admission photo in which R38 had a thick white and gray mustache. On 5/9/16, at 7:00 p.m., R38 was observed sitting in his wheelchair. White hairs, approximately 1/8" (inch) long, were noted on his upper lip and scattered on both cheeks. On 5/10/16, at 11:33 a.m., R38 was observed with the same white hairs on his upper lip and scattered on both cheeks. The stubble was approximately the same as the day before. On 5/11/16 at 8:24 a.m., family member (FA)-1 had concerns that R38 was not being shaved often enough. FA-1 further thought that R38 was only receiving assistance with shaving once a week. FA-1 stated that shaving was very important to R38, who had been "the most particular person you can imagine" regarding shaving. FA-1 went on to state that shaving "was a huge thing for him." FA-1 stated R38 always kept his mustache in his younger years and would "not feel good" about the mustache being shaved. On 5/11/16, at 7:14 a.m., R38 was again observed sitting in his wheelchair, waiting by a	2 920		

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2 920	Continued From page 56 medication cart. R38 continued to have white facial hair on his upper lip and cheeks. The hair on R38's upper lip and cheeks was longer than when observed on 5/9/16. On 5/12/16, at 7:43 a.m., R38 was observed sitting in wheelchair eating breakfast in the dining room. His hair appear wet and had been combed. R38 stated he had had a bath that morning. The white hair on his upper lip and cheeks was now approximately 1/4" long. On 5/13/16, at 10:10 a.m., nursing assistant (NA)-M stated that R38 received grooming, bathing, and shaving assistance from the hospice aides and the facility nursing assistants. NA-M stated shaving was the responsibility of the facility nursing assistants, not hospice. NA-M stated R38 had his own razor and there was a floor razor for resident use as well. NA-M stated R38 never refused offers to shave and NA-M shaved him that morning. NA-M reported that shaving was a routine, some residents would say yes or no, some would say "go right ahead." Later that same day at 11:29 a.m., R38 was observed sitting in his wheelchair looking out the window. His face was clean shaven, including the hair on his upper lip. R38 was stated he did not like having a beard but "a mustache I like." On 5/13/16, at 1:39 a.m., licensed practical nurse (LPN)-B stated R38 was shaved by both hospice and facility staff and went on to state that most residents were shaved every third day. LPN-B stated nursing staff would shave a resident if they needed it because they would "see it [facial hair]." LPN-B further stated residents' care plans identified how often they needed to shaved or groomed.	2 920		

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2 920	Continued From page 57 On 5/16/16, at 10:38 a.m., LPN-A stated shaving was suppose to be a daily event and was included in "grooming." LPN-A was unaware of any assessment regarding facial hair and whether or not a resident wanted to keep a mustache. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure all residents personal preferences with activities of daily living are met. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 920		
21230	MN Rule 4658.0700 Subp. 2 B Medical Director; Implement ResCare Policies Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for: B. implementation of resident care policies; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director to address concerns related to significant issues for 3 of 3 residents (R11, R51, and R54) reviewed who excessively consumed alcohol. Findings include:	21230		

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21230	Continued From page 58 See F323. The facility failed to comprehensively assess and develop interventions to reduce the risk of significant harm to 3 of 3 residents (R11, R51, and R54) who excessively consumed alcohol and regularly became intoxicated. This resulted in an immediate jeopardy situation for R11, R51, and R54. When interviewed on 5/17/16, at 2:58 p.m. the medical director (MD) stated he is not the primary physician for any of the residents at the facility, but is the medical director. MD denied being aware that any of the residents were drinking outside of the gazebo program, stating "and that bothers me." Nothing has been brought up to him about residents drinking. Further MD stated when the program was held outside, there were issues discussed, and brought into the quality assurance meetings. He stated he was aware there are occasionally people that go out to drink, but was not aware there was a problem, but more of an isolated issue. MD also stated he was not aware of residents repeatedly not following the rules. He would expect there be an incident report filled out, and the incident reports specifically related to alcohol be brought to him for review. When reviewing the breathalyzer results of the residents, MD stated be was "agast" that nursing did not do a report on these. Years ago, MD stated he suggested the breathalyzer, and expected there was a policy in place as to what to be done with the specific readings. MD stated the facility has not reached out to him for assistance in what to do if residents are refusing breathalyzers tests. A result of 0.256, would indicate substantial drinking, with the person quite intoxicated and at risk for falling. At 0.307, would indicate an increased risk of falls. There is also potential of issues with the resident's	21230		

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21230	Continued From page 59 medications. MD stated he was not aware of anyone refusing a breathalyzer, identifying they cannot allow nothing to be done. The delima is what to do if someone is not cooperative. The real issue is monitoring, and the facility has to pay more attention to prople leaving the building. There needs to be a policy on monitoring residents that are intoxicated. Door monitors need to be more accountalbe. The high risk residents need to be monitored, incident reports completed, and they need to be brought to quality assurance. Medical Director Agreement signed 6/10/13, identified the provider is responsible for the overall coordination of medical care at the facility. Coiodination of care means provider shares responsibility for assuring facility is providing appropriate care as required which involves monitoring and ensuring implementation of resident care policies and providing oversight and supervision of physician services and medical care of residents. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing (DON) could ensure collaboration with the medical director regarding resident policies and procedures including alchol consumption. The facility could ensure the medical director reviews all policies, procedures, and incident and grievance reports to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21230		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		

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21375	Continued From page 60 Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive infection control program that included comprehensive surveillance of resident symptoms and cultures and analysis of that surveillance. This had the potential to affect all 85 residents residing in the facility. Findings include: During review of the facility's Monthly Infection Control Logs from 3/15 to 5/16, the following infections were identified: 9 urinary tract infections (UTI's), 17 respiratory infections, 11 cellulitis/wound infections, and 2 unidentified infections. All UTI and respiratory infections were treated with antibiotic therapies, however; the logs lacked evidence of cultures and symptom tracking to support antibiotic use. Antibiotics were either changed or extended on 2 UTI's and 3 respiratory infections (excluding aspiration pneumonia) without evidence of cultures/symptoms to support the change or extension of antibiotic therapies. The logs identified antibiotic changes for 1 UTI and 1 respiratory infection occurred due to hospitalization or "acquired healthcare." The facility lacked any documented analysis of the surveillance infection control logs. On 5/13/16, at 2:37 p.m., the director of nursing (DON) stated the infection control logs were filled	21375		

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21375	Continued From page 61 out by the floor nurses as the infections occurred. The logs were reviewed by her and in their monthly quality assurance (QA) meetings, but she did not have a written analysis of the surveillance. The DON stated she received a list of antibiotics the first week of every month for the previous month. She also noted the antibiotic changes that occurred while residents were hospitalized and stated the expectation would be to obtain the cultures and document on the logs. She further stated symptoms were documented in the residents' progress notes. No symptoms were documented on the logs. The facility policy Infection Control Program, revised in 2013, established the intent of the program was to "provide surveillance, investigation and monitoring to prevent, to the extent possible, the onset and the spread of infection." Furthermore, the policy identified surveillance/monitoring as to "review microbiology culture and sensitivity reports on a regular basis to identify types of organisms causing infections, monitor for antibiotic resistant organisms, and identify potential transmission of organisms between residents" and to "perform surveillance for infections, compile and analyze data, prepare and bring reports to the Infection Control oversight committee." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise infection control policies and procedures to ensure adequate tracking and trending of resident infections. The DON could ensure the infection control program analyzed resident infections identifying patterns and trends, antibiotic, culture, and symptom tracking, and provide training to involved staff. The quality assurance team could audit the system to ensure program ongoing	21375		

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21375	Continued From page 62 compliance with the infection control program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to maintain documentation of tuberculosis symptom screening for 3 of 5 employees (NA-A, NA-B, LPN-A) and failed to administer the tuberculin skin test within 72 hours admission for 2 or 5 residents (R100, R38) with	21426		

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21426	Continued From page 63 no previous history of tuberculosis testing prior to admission. Findings include: The Facility Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH), completed 2/6/16, identified the facility as medium risk for TB infections. Facility policy entitled: Tuberculosis Screening-Employees, revised in 2013, indicated that new employees of the facility be tested and screened for TB upon hire and with an annual screening. The policy also indicated that a new employee could start working if the first tuberculin skin test (TST) and employee risk screening tool (symptom screen) were negative. Employee files were reviewed and contained the following: Nursing assistant (NA)-A was on hired 3/23/16. NA-A's employee file contained a chest X-ray, dated 8/17/15, to rule out TB, but did not contain a symptom screen for active TB symptoms when hired. NA-B was hired on 4/20/16. NA-B's employee file contained a chest X-ray, dated 1/29/16, and medical evaluation, dated 3/1/16, to rule out TB, but did not contain a symptom screen for active TB symptoms when hired. License practical nurse (LPN)-A was hired on 3/19/16. LPN-A's employee file contained a Quantiferon-TB Gold (TB blood test), dated 11/22/14, but did not contain a symptom screen for active TB symptoms when hired. On 5/16/16, at 11:11 a.m., human resources (HR) confirmed that there was no additional TB	21426		

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21426	Continued From page 64 information in the employee files. Facility policy entitled: Tuberculosis Screening-Residents, revised in 2013, indicated that "for all new admissions a tuberculin skin test (TST) will be done within 72 hours after admission if there is no documented TST result from within 3 months prior to admission." Resident medical records were reviewed and contained the following: R100 was admitted to the facility on 5/5/16. A symptom screen for active TB was completed upon admission. However; R100's first TST was not administered until 5/13/16. A physician's order for the two step TST was obtained on 5/13/16. Immunization sheets from R100's previous facility indicated his last TST was in August/September of 2014 (almost two years prior). R38 was admitted to the facility on 5/21/15. A symptom screen for active TB was completed upon admission. However; R38's first TST was not administered until 5/26/15. A physician's order for a TST to be administered was obtained on 5/26/15. No previous TST documentation was obtained. During interview on 5/13/16, at 2:37 p.m., the director of nursing (DON) stated it was policy for residents to receive the first TST within the first week of admission, if they had not had one previously. The DON stated R38 was admitted from a short term rehab facility. Documentation of TB status from that facility was requested. On 5/16/16, at 11:16 a.m., the DON stated R100 was admitted from a different facility and confirmed his last TST testing had been in 2014. She also stated the first TST should have been	21426		

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21426	Continued From page 65 administered within the 72 hours if an order was obtained. Additional information was requested but not provided. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor resident and employee TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide meaningful	21435		

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21435	Continued From page 66 activities for 1 of 3 residents (R16) reviewed for activities. Findings include: R16's care plan dated 4/14/16, indicated R16's diagnoses included schizoaffective disorder, Alzheimer's disease, and chronic obstructive pulmonary disease (COPD). An annual Minimum Data Set (MDS) dated 5/6/16, indicated R16 had severe cognitive impairment. It also indicated R16 felt it was very important to listen to music, have newspapers/magazines to read, to do things with groups of people, and important to go outside and get fresh air. A quarterly MDS dated 2/5/16, indicated R16 was independent with ambulation. R16's care plan directed staff to invite and encourage R16 to attend upcoming programs of interest such as televised sporting events, socials and special events. A Therapeutic Recreation Interest Survey dated 5/15/15, indicated some of R16 interests included smoking, cards, Bingo, painting, sports, newspapers, music, and television. An activity calendar dated 5/16, indicated some of the activities that were planned included Bingo, morning music, creative arts, movies, gardening, and cards. A daily activity log dated 5/1, 5/3, 5/5, 5/6, 5/9, 5/10, and 5/11/16 did not indicate R16 was asked to participate in the activities, if R16 refused activities, or if R16 attended any activities. On 5/11/16, at 2:37 p.m. R16 was observed smoking with other residents in the second floor smoking room. At 3:23 p.m. R16 was sitting in the dining room with a view of the smoking room.	21435		

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21435	Continued From page 67 R16 was not observed in any group or individual activity. On 5/11/16, at 3:25 p.m. with R16 stated he went to activities when they were offered. R16 got up from the chair in the hallway and walked into the smoking room when it was opened. R16 stated he was going to have a cigarette now. On 5/11/16, at 3:28 p.m. the director of activities (DA) stated resident's needed a lot of encouragement to try things in their rooms and on thier own. The DA stated every resident should be invited to the activities. The DA stated if R16 were approached for an activity then it should be documented on the activity log. The DA stated there is a big problem here with documentation. A facility policy Basic Activity Program-Steps to Follow Each Time When Running a Program dated 2/14 directed staff to document the participant's involvement in the activity. SUGGESTED METHOD OF CORRECTION: The activity director (AD) could develop systems to ensure residents are offered and encouraged to attend activities of preference. The AD could ensure individualized resident choices are available as able. The activity director could educate all staff on these systems. The AD could develop programs to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social	21495		

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21495	Continued From page 68 services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide medically related social services for residents who abuse alcohol, to ensure consistent implementation of established facility protocols and/or to assist with discharge planning for 2 of 3 residents (R11 and R51) reviewed for alcohol use and other behaviors. Findings include: When interviewed on 5/17/16, at 12:50 p.m. the social services director (SSD) stated part of her role with chemically dependent residents is determining their history. The SSD stated during the initial care conference, she lets the interdisciplinary treatment team (IDT) know what is appropriate for the individual resident. The SSD acknowledged if residents drink "too much" they could be a danger to themselves or others, but was unable to define what "too much" was, she stated "definitely if they get alcohol poisoning, or if [R51] would have a seizure, that would be too much." R11's quarterly Minimum Data Set (MDS) dated 3/8/16, identified admission to the facility on 3/1/02. It also identified R11 had modified independence with cognitive skills for daily decision making, and demonstrated feeling down, depressed or hopeless. R11 was noted to be	21495		

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independent with activities of daily living (ADLs). Active diagnoses included diabetes mellitus, non-Alzheimer's dementia, anxiety, depression, cognitive communication deficit, alcoholic cirrhosis of liver, and alcohol dependence. The MDS also identified R11 exhibited other behavioral symptoms not directed toward others, and rejection of care.

R11's behavioral symptom Care Area Assessment (CAA) dated 7/2/15, identified R11 had episodes of impaired judgment and poor decision making, noting an episode in which he was in a verbally aggressive altercation with another resident which lead to threatening and physical aggression. "He also has been warned about not going out into the community to drink alcohol or take drugs and/or bring anything back in with him." The CAA documentation lacked any direction or guidance in dealing with these behaviors.

R11's medical record lacked a comprehensive assessment related to safety of alcohol use.

R11's medical record lacked a signed Alcohol and Drug Use policy. The face sheet identified R11 as his own responsible party.

R11's care plan dated 4/8/16, identified a potential alteration in cognition related to alcohol dependence. It also identified a history of going out 'for a few drinks'. Interventions included: encouraging sobriety, Level I monitoring (date initiated 12/11/11), private room due to inability to get along with roommates, and identifying physical and verbal aggression. The care plan also indicated R11 was at moderate risk for falls due to alcohol or drug use. Interventions included: independent with transfers, and observe

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orthostatic blood pressure monthly. The care plan lacked specific interventions related to alcohol use.

The facility provided a Resident Classification Listing by Room dated 4/18/16. R11 was identified as a Level II (which contradicted information provided on the care plan).

On 5/16/16, at 10:01 a.m. the social service director (SSD) was asked about the conflicting level information for R11. The SSD stated she was unsure why R11 was a Level II on the Resident Classification Listing. The SSD stated, [R11] "is a Level I, and has been since 9/23/12. Everyone knows this."

R11's Fall/Safety Risks Evaluation and Assessment dated 3/7/16, failed to indicate R11 had a current issue with alcohol and/or drug use, an extensive history of alcoholism, alcoholic cirrhosis of the liver, drunkenness, and alcohol-induced persisting dementia. The assessment indicated "occasionally resident is confrontational with staff and other residents, especially if drinking alcohol."

Review of R11's progress notes dated 4/22/15 through 5/14/16, identified the following incidents:

- 5/4/15, at 10:24 p.m. R11 went for a walk at 6:55 p.m., and returned at 9:10 p.m. Refused breathalyzer, stating, "I'm not on the Gazebo program. I don't have to do that anymore." (The facility's Gazebo Alcohol Program [A program run by the facility, which allows residents to drink a physician approved, set amount of alcohol provided by staff, in a specific area of the building at a specific time each day]).

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21495	Continued From page 71 - 5/23/15, at 3:50 a.m. R11 exited his room, agitated, jumping from one subject to another, at times not making sense, talking about drinking in his room. - 5/23/15, at 9:45 a.m. R11 had been speaking to staff in a "foul language". It also noted R11 shared with dietary staff he had been drinking. The documentation included: "In a brief glance around room do not see any alcohol bottles/containers." - 5/24/15, at 3:30 a.m. identified at 9:50 p.m. R11 was observed blocking the door entrance, with the door monitoring staff outside. R11 began yelling racial slurs to staff and threatening to "physically harm the door monitor." R11 walked toward staff in a threatening manner, swearing, and was informed if he physically harmed staff, the police would be called. R11 went to his room, and returned at 10:05 p.m. cursing, gritting his teeth, and leaning on the nursing station. He was informed the police would be called if he didn't calm down. It was also noted R11's eyes were "extremely blood shot." R11 was checked on x 2 [twice] and appeared to have calmed down. - 6/17/15, at 12:00 p.m. R11 confronted and had a verbal altercation with a peer, and when being escorted out of the dining room, began to threaten the peer, making the motion of a fist, and attempted to get back in the dining room. The note indicated R11 had slurred speech and suspected he had been drinking. R11 stated, "Did he laugh at me, I'm gonna knock the shit out of him." A corresponding incident report dated 6/16/15 was completed, but lacked any additional content. - 6/17/15, at 5:55 p.m. the SSD and administrator	21495		

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discussed recent behaviors with R11, and he was informed he could not drink in or out of the building unless in the gazebo program. The notes indicated if the resident gets intoxicated he has to cooperate with the nurses when they ask for a breathalyzer and if he doesn't comply he will be sent to the hospital and/or the police will be called to assist. He stated that he understood and certainly did not want the police called due to his behaviors. Finally he was told that he will be given a notice to discharge if there are any more incidents, he responded with "I am leaving soon anyway" and when asked where he was going he could not give an answer. The documentation indiated the administrator had reiterated everything one final time and the resident had verified he understood. A couple of hours later the resident had asked whether if they would find him a place to go if given a discharge notice.

- 6/19/15, at 9:30 a.m. (documented as a late entry) identified R11 was told that he would be given notice to leave if his behaviors continued.

- 7/5/15, at 5:36 p.m. R11 had a verbal altercation with a peer, threatening to "beat each other up." Four staff intervened until the peers walked away from each other.

- 7/7/15, at 7:46 p.m. R11 was in a verbal altercation with a peer, entering peer's room, yelling and cursing at peer.

- 7/10/15, at 3:12 p.m. R11 complained of abdominal pain, and an abdominal x-ray was ordered. R11 stated, "Don't send them in my room, I'll kill them."

-8/20/15, at 1:24 a.m. R11 was complaining about issues to staff. He then began cursing and

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21495	Continued From page 73 became agitated. - 9/4/15, at 4:32 p.m. staff reported to nurse R11 appeared to be drunk. The SSD and administrator entered R11's room with the breathalyzer. When asked if he had been drinking last night or this morning, R11 denied it. His speech was somewhat slurred. Breathalyzer read 0.204, and a retest of the breathalyzer was 0.203. "This writer and Administrator then reminded him of a discussion in which he stated that he understood that if an incident like this happened again he would be given a notice to leave. He said that he remembered this. This writer then informed him that a referral would be made for the Glennwood, (wethouse) [a residential facility for chronically alcoholic and homeless men and women], so that discharge planning could begin. He stated understanding of this." - 9/8/15, at 10:22 p.m. R11 was found on the floor near the door in his room. He appeared drunk but refused breathalyzer and vital sign assessment. Resident stated "don't call the police I am already in trouble." Corresponding incident report completed, identified plan to "possibly" give resident a 30 day notice to discharge. - 9/9/15, at 5:44 p.m. Staff reported R11 appeared drunk. SSD and another staff entered R11's room. R11 refused breathalyzer. He was informed if he did not do the breathalyzer, "it was the same as saying that he had been drinking." R11 continued to refuse, and closed his eyes. - 10/19/15, at 6:15 p.m. R11 left facility at 8:30 p.m. and returned at 9:50 p.m. Breathalyzer read 0.105.	21495		

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21495	Continued From page 74 - 10/23/15, at 10:19 p.m. R11 went out from 5:45 p.m. - 9:35 pm. Breathalyzer read 0.162. - 10/31/15 at 7:15 p.m. R11 had a verbal altercation with housekeeping. A corresponding incident report completed on 10/31/15 lacked any further information. - 11/7/15, at 7:27 p.m. R11 went out at 6:50 p.m., returning at 7:11 p.m. Breathalyzer read 0.022. - 11/9/15, at 9:45 p.m. R11 left at 8:00 p.m., and returned at 8:50 p.m. Breathalyzer read 0.077. - 11/16/15, at 12:30 a.m. R11 to the nurses station asking for medication he had previously refused. He became "very upset and began cursing". Staff attempted to talk with R11, but he refused to listen and walked off to his room. - 11/16/15, at 6:30 p.m. R11 out of the building from 6:30 p.m. - 8:30 p.m. Breathalyzer was 0.08. - 11/19/15, at 10:54 p.m. R11 out of the building and breathalyzer read 0.06 upon return. When interviewed on 5/11/16, at 4:21 p.m. the DON stated breathalyzer was below the legal limit, and she wouldn't expect any increased monitoring. The DON stated she was not notified, and would expect herself or the SSD to have been notified of any incident involving drinking of any amount, and would expect an incident report completed. - 12/24/15, at 5:30 p.m. R11 was found with two cans of beer in his room, observed to be dumping it down the drain when staff entered. R11 began	21495		

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cursing, slammed the cabinet door shut with his foot.

On 5/11/16, at 4:21 p.m. the DON stated no breathalyzer was done. The DON also stated a room search revealed no further alcohol, and she was notified of this incident. There were no further symptoms, and she would not expect 15 minute checks. Further, the DON stated R11 was aggressive, but he was also aggressive without alcohol.

- 3/29/16, at 9:13 p.m. R11 left the facility at 6:20 p.m. and returned at 9:20 p.m. R11 reported being down by the lake, and breathalyzer reading was 0.143.

- 4/13/16, at 9:06 p.m. R11 left the building and refused breathalyzer upon return.

- 5/7/16, at 6:40 p.m. R11 left the facility at 2:05 p.m. and returned at 6:39 p.m. Breathalyzer read 0.256. Resident went to his room.

On 5/11/16, at 4:21 p.m. the SSD stated R11 was not on the Gazebo program because he didn't want to follow the rules, and it was 'his right to drink'. The DON also verified that on 5/7/16 when R11's breathalyzer reading was so high, R11 had gone to his room. The DON was unable to provide any documented assessment at that time such as vital sign readings, or increased clinical and safety monitoring having been done. The DON stated she would have expected an incident report and 15 minute checks to have been completed.

R11's Social Services Review notes dated 3/10/16, identified "He does display some short term memory deficits some of which could be

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selective memory. He has episodes of impaired judgement." The notes also included, "He can also be verbally aggressive towards staff especially when they want him to do something. He does not want anyone in his room even after knocking. He has episodes of drinking inside or outside of the building and then denying that he has. Social Service will remain actively involved through 1 to 1 visits and behavior management interventions as needed."

During interview with the SSD, she stated the original plan for R11 was to discharge him to a wethouse [a residential facility for chronically alcoholic and homeless men and women]. However, he was not accepted there because he has a colostomy, and even though he is independent with the cares of his colostomy, there was a concern from the wethouse about shared bathrooms. The SSD verified the nursing home was not an appropriate placement for R11, as he requires no skilled care, and stated she had been trying to convince him to go to a more independent setting, but stated there was no current plan in place for discharge.

The SSD stated on 5/17/16 at 12:50 p.m., that R51 remained adamant he wanted to continue to drink, and that a reason he wanted to come to this nursing home was to be a part of the alcohol program. The SSD verified no discharge plans were in progress for this resident.

R51's quarterly MDS dated 4/28/16, identified the resident had modified independence in cognitive skills for daily decision making, behavioral symptoms not directed toward others, and required the use of a wheelchair. Diagnoses included hypertension, diabetes mellitus, seizure disorder/epilepsy, and depression.

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21495	Continued From page 77 R51's CAA dated 11/3/15, identified diagnoses of acute alcohol intoxication/withdrawal, physical weakness, depression, limited range of motion, poor coordination, poor balance, and visual impairment. It also identified behavior problems including disruptive, loud talking in the dining room "especially after Gazebo/alcohol program." The CAA noted impaired balance during transitions, and difficulty maintaining sitting balance as well as agitation and decreased mobility. The CAA lacked any direction or guidance in dealing with these behaviors. R51 did not have a comprehensive assessment related to the safe use of alcohol. R51's medical record included a signed contract to participate in the Gazebo program dated 8/7/15. However, there was not a signed Alcohol and Drug Use policy. The face sheet identified R51 as his own responsible party. R51's care plan dated 4/27/16, identified a self care performance deficit related to alcohol use. It also identified R51 had a potential risk for falls related to being wheelchair bound, and the use of alcohol with the Gazebo program. The plan of care indicated both long and short term memory problems, and poor judgement and decision making due to alcohol dependence. The care plan also identified an alteration in mood and behavior related to acute alcohol intoxication/withdrawal. Interventions included to remind of the rules around the gazebo/ alcohol program. The care plan failed to identify R51's alcohol monitoring level. The Resident Classification Listing By Room form, dated 4/18/16, identified R51 as a Level III.	21495		

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21495	Continued From page 78 Review of R51's progress notes from 4/28/15 - 5/15/16, identified the following: A Physician Progress Note for R51 dated 6/2/15, identified "Patient has remained stable since he returned from the hospital in February for alcohol intoxication. Patient continues to smoke and consume controlled amount of alcohol here at the facility." - On 7/1/15, at 6:47 p.m. it was reported that resident (R51) was drinking outside the Gazebo program. "Client monitored closely". Blood pressure upon waking is 75/54 and heart rate 75. Given meal tray and drank 300 ml (milliliters) of water. Blood pressure at 6:30 p.m. 87/53. Physician notified and orders received to check blood pressure every four hours and continue to encourage fluids. Other notes from this date identified resident left at 10:35 a.m. with his niece and returned at 1:05 p.m. He was searched and breathalyzer was 0.258. Staff found a bottle of whiskey in his room, which was locked in the liquor cabinet. An incident report was completed for this incident on 7/1/15, noting "Resident was instructed to not drink." The record lacked evidence their Gazebo policy was followed. On 5/11/16, at 3:02 p.m. the SSD stated, "if they mess up like this when in the program, they would be suspended for 3 days, or a week if they are sent to the hospital or detox." - On 7/2/15, at 10:48 a.m. a note indicated R51 had been seen by the nurse practitioner, and the note indicated R51 is an adult and can drink and smoke when he wants. "He is not hurting himself or anyone else." - On 7/2/15, at 1:59 p.m. a note identified R51	21495		

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21495	Continued From page 79 was on a three day suspension from the Gazebo program. A Physician Progress note for R51 dated 7/2/15, identified the chief complaint as alcohol intoxication. It noted resident had a breathalyzer reading of 0.258, and blood pressure was noted to be low at 87/56, with a retake at 75/54. The note indicated during interview with the physician the resident had stated, "I am fine, I went out with someone and had some drinks. I am an adult and I will do whatever I want. I am here because I can drink and smoke. If I get the opportunity again, I will do it. I am not hurting myself or anyone else when I drink, so I should be left alone." The nursing progress notes indicated R51 was allowed to sleep it off, there was no report of aggressive behavior towards staff and included, "Patient will be off Gazebo program for three days. Nursing will continue to monitor for any sign of withdrawal." - On 7/8/15, at 1:20 p.m. the notes indicated R51 was restricted from the gazebo program due to having the bottle. - On 8/6/15, at 10:11 p.m. notes indicated the resident had left with his niece at 2:15 p.m. and returned at 3:45 p.m., appearing drunk and very talkative. "Social worker notified, and resident will be monitored." It was also documented R51 had refused the breathalyzer as well as other assessments. The record lacked evidence the Gazebo policy was followed. - 8/17/15, at 3:51 p.m. resident left after the Gazebo program in a taxi at approximately 3:13 p.m., attempting to take a peer with him. The documentation indicated the SSD had attempted to stop the resident, but he'd left anyway and had	21495		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21495	Continued From page 80	21495		

returned at approximately 3:46 p.m. with a brown paper bag, and a bottle of alcohol in it. The notes indicated staff had taken the bag, and the resident was verbally abusive toward staff. The record lacked evidence the Gazebo policy was followed.

On 5/11/16, at 3:02 p.m. the DON stated the alcohol was taken from R54 and locked up in a cabinet. A Code B (a behavior that cannot be controlled, where all available staff come to help) was called since R54 was following the staff and threatening her. When the nurse went in, R54 was intoxicated, slurring his words. Breathalyzer at this time was 0.336, and his blood pressure was running low. The on call physician was called, and instructed staff to monitor resident, encourage fluids, and to call back if there was a decline.

- On 8/17/15, at 11:10 p.m. noted resident was examined by a registered nurse in his room at approximately 7:25 p.m. He was "clearly intoxicated, fatigued, and slurring his words." Breathalyzer was 0.336. Blood pressure 94/59 and 86/54. Physician notified and orders received to monitor resident and encourage fluids. Call back with a decline. At 10:00 p.m. blood pressure was 146/82. Also noted at this time to be more awake, not slurring words, and drinking fluids. The record lacked evidence the Gazebo policy was followed.

- On 8/18/15, at 2:57 a.m. noted at approximately 12:15 a.m. staff attempted to obtain vital signs, and resident was increasingly agitated, using foul language. Noted staff obtaining frequent checks on resident every one to two hours for safety.

A Physician Progress Note dated 8/21/15,

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21495	Continued From page 81 identified a review of the incident [dated 8/17/15] where resident returned to the facility and had a breathalyzer of 0.33. The note indicated the vital signs were now normal and resident is back to his baseline. During interview with the physician, R51 stated he was "angry that the social worker can not allow him to bring his own 'Booze' into the facility. He was also angry that he will be off the Gazebo program for 3 days since he got himself intoxicated." The progress note identified no education and no orders were provided for increased monitoring when R51 was intoxicated. Then note indicated nursing was to continue to monitor for any signs or symptoms of withdrawal. - On 9/28/15, at 10:36 p.m. resident returned to the facility via taxi at approximately 6:00 p.m. and was met at the door by the SSD. He turned in his alcohol bottles, and breathalyzer was 0.141. Resident was informed by the SSD he will not be attending Gazebo tomorrow. On 5/11/16, at 3:02 p.m., the SSD stated R51 liked to go out and drink with his meals. She verified the Gazebo policy identified that drinking outside the program would result in a one week suspension, which had not been enforced in this case. - On 10/24/15, at 1:33 p.m. notes indicated R51 had refused to shower the evening before, and had been informed he could not attend the Gazebo program, so had become very upset and angry. - On 11/5/15, at 11:24 p.m. identified R51 had returned at 5:35 p.m. from going out on a visit with his brother [left at 12:05 p.m.] The note indicated he was drunk and went to his room after being searched. The record lacked evidence the	21495		

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21495	Continued From page 82 Gazebo policy having been implemented. On 5/11/16, at 3:02 p.m. the SSD stated there should have been a restriction for not following the gazebo contract. - On 12/4/15, at 10:26 p.m. the notes indicated R51 had gone out at 12:05 p.m. At approximately 6:00 p.m. a call had been received about the resident being drunk at a local liquor store, and being under supervision of the police. R51 had been sent to the hospital. The hospital visit note dated 12/4/15, indicated R51 had arrived via ambulance. "Report that patient was outside a liquor store in Plymouth with intoxication. Police were called. Arrives with appearance of intoxication and slurring words. Patient is wheelchair bound. Reportedly lives at Mission detox center." Further information included, "Patient was conversing in room when he had loss of consciousness on the cart lasting about 30 seconds. Patient unresponsive to sternal rub. Came to after 30 seconds and started yelling incoherently." The last note from this visit identified "Pt [patient] increasing agitation; numerous requests for his belongings and to be allowed to leave. MD [physician] in room speaking with pt." On 5/11/16, at 3:02 p.m. the DON stated dispatch had called the facility regarding the 12/4/15 incident. The SSD also stated R51 had gone out to eat, and the restaurant was across from a liquor store. The SSD stated R51 had left the restaurant and gone to the liquor store. Staff at the liquor store had subsequently called the police, reporting someone intoxicated. The SSD stated the facility did not have a copy of the police report. The DON stated she'd instructed dispatch to take R51 to the hospital for evaluation. Upon	21495		

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return to the facility after six hours, R51 had refused the breathalyzer or vital signs. The DON said R51 had been demanding staff call the police and hospital to return his alcohol. Staff had calmed him down and R51 returned to his room. The DON stated no alcohol levels or reports were available from the hospital. There was no record if a physician was contacted for any orders of increased monitoring. The DON confirmed her expectation that increased monitoring would be completed as well as an incident report. The DON also stated R54 had posted a note on his door stating he was not to be disturbed unless it was for the gazebo. The SSD stated R51 had to eat lunch, or he would not be able to attend the gazebo program and added, "He is taking it more serious lately because it is important to him."

- On 12/5/15, at 1:47 p.m. documentation indicated R51 had not been allowed to attend the Gazebo for breaking rules yesterday [12/4/15] (drinking alcohol outside the Gazebo program).

- On 12/5/15, at 6:49 p.m. notes indicated R51 had not been allowed to attend the Gazebo program until re-evaluated after the weekend.

When interviewed on 5/11/16, at 3:02 p.m. the SSD stated at that time R51 had been restricted from the Gazebo program for one day, which she verified did not correlate with the Gazebo Alcohol Program Contract which directed a one week violation for drinking outside of the gazebo program.

A Psychology Progress Note dated 2/16/16, identified R51 had been treated for depressed mood and alcohol use disorder. "Patient is now want [sic?] to control drinking program. He has not had any acute binge episodes that I am aware

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21495	Continued From page 84 of recently." Previous visit with psychology was dated 11/17/15. - On 1/10/16, at 1:44 p.m. notes indicated R51 quickly returned from the Gazebo program after receiving ice from staff. There was a covered coffee cup noted behind the resident. R51 was asked if staff could check the cup, and after R51 stated "yes" it was noted to smell of alcohol. The cup was taken, and the resident chased staff around the front lobby. The note indicated the SSD had been notified and R51 was restricted from the Gazebo the following day for breaking rules. The record lacked evidence the Gazebo policy was followed, which directed a one week violation for drinking outside of the Gazebo program. - On 2/3/16, at 4:53 p.m. R51's quarterly note identified when he participated in programs after the gazebo program, he was noted to be talking inappropriately/making sexual comments. - On 2/29/16, at 7:32 a.m. R51 refused to have a Keppra level drawn, and became verbally aggressive with the phlebotomist. The notes indicated R51 had come to nursing station later, stomping his feet and yelling he did not want to be awakened for anything but the Gazebo program. On 5/11/16, at 3:02 p.m. the SSD stated R51 had a history of only wanting to be awakened for the Gazebo program, stating he'd been informed he needed to eat lunch before attending the program, and had been compliant with this. The SSD stated there had been no restriction from the gazebo program for refusing therapy/services, or from behaviors of yelling at staff when they enter his room to offer services.	21495		

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21495	Continued From page 85 - On 3/13/16, 12:19 p.m. notes indicated R51 had been yelling at staff in his room for waking him to administer insulin, and had stated the sign on his door indicated to never wake him except for the gazebo program. - On 3/13/16, at 9:41 p.m. notes indicated R51 had again stated staff should only wake him for the Gazebo program. - On 3/14/16, at 2:49 a.m. resident was noted to be offered insulin prior to lunch. The notes indicated R51 had stated, "NO...DO NOT EVER WAKE ME...ONLY WAKE ME FOR GAZEBO." - On 3/31/16, at 5:45 p.m. Therapy discontinued for gait training due to resident either refusing or attempting to be seen after the gazebo program. - On 4/12/16, at 3:00 a.m. R51 was informed of an emergent call from his son. R51 stated "I do not care if it is an emergency. I only want to be woke up for GAZEBO." - On 5/6/16, at 8:55 p.m. R51 requested to never be awakened for anything but the Gazebo. On 5/13/16, at 10:44 a.m. R51 was interviewed and stated he had been at the facility for about a year and a half, and had been part of the Gazebo program ever since. He said he'd agreed to come to this nursing home "because I was able to drink and smoke." R51 stated he signed a contract for the program, but was not exactly sure what it specified. "I didn't read it thoroughly. I had to sign to participate." Further, R51 stated the alcohol was purchased by the SSD, and it was locked up. "I have been restricted on one or two occasions, when I drank more than I should	21495		

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have." R51 stated when he was hospitalized, he had only been restricted for 1-2 days. "I don't drink on outings anymore. I have nobody locally to take me on outings. I would if I could." The facility knows if I go out "I am probably gonna drink. I'm not driving."

When interviewed about the facility's Gazebo program on 5/11/16, at 4:05 p.m., the SSD stated residents need to ask to be on this, and are then evaluated by the interdisciplinary team (IDT). The SSD said she evaluates whether the resident is appropriate behaviorally to be on the Gazebo program, and then nursing and the physician evaluate if they are appropriate medically. The SSD stated, "if a resident drinks outside the gazebo program, the policy spells out the consequences", and that her hope was that the policy would be followed.

The facility's undated policy Alcohol and Drug Use, identified: "Purpose: A primary mission of Mission Nursing Home is to provide care to residents who are chronically chemically dependent. While encouraging and supporting the efforts of residents to maintain sobriety, the facility also recognizes that some persons will relapse or continue to use alcohol and drugs. This policy is adopted to provide guidelines on the use of alcohol and drugs, with the goals of a safe and healthy environment in mind, while also supporting and encouraging sobriety." In addition the policy included:
1. Mission Nursing Home will support any and all efforts at sobriety and is available to give you assistance at all times.
2. In order to participate in the Gazebo program, the resident will be assessed by therapy, nursing, and the behavior management committee.
3. The use or possession of alcohol in the

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21495	Continued From page 87 building is not permitted. Random room searches are conducted to ensure there is no alcohol in the building. 4. Inappropriate behavior resulting from the use of alcohol will not be allowed and will be addressed according to the facility behavior management policy. An undated facility policy titled Behavior Policy, indicated "violent, criminal or inappropriate sexual behavior in public will not be tolerated by Mission Nursing Home. Residents who engage in such behavior in public will be discharged from the facility." Examples of such behavior included assault (including threats of assault). The policy also identified other inappropriate behavior in affecting the health, safety, or welfare of the resident and/or the community would not be allowed. "Residents who engage in such behavior in public and who repeat the behavior twice will be discharged from the facility." Examples of such behavior included self-endangerment. SUGGESTED METHOD OF CORRECTION: The social service director (SSD) could develop systems to ensure residents have their needs met related to treatment options and availability related to alcohol use. This could include their resident rights and the rights of other resident related to the ongoing use of alcohol. The SSD could educate all appropriate staff and residents on these systems. The quality assurance committee could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		

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21510	Continued From page 88	21510		
21510	MN Rule 4658.1200 Subp. 2 A.B. SpecializedRehabilitative Services; Provision Subp. 2. Provision of services. If specialized rehabilitative services are required in the resident's comprehensive plan of care, the nursing home must: A. provide the required services; or obtain the required services from an outside source according to part 4658.0075. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure an individualized service plan was included as part of the assessment and care planning process for 1 of 1 resident (66) reviewed for Preadmission Screening and Resident Review (PASRR). Findings include: R66's admission Minimum Data Set (MDS) dated 3/10/16, indicated R66 was cognitively impaired. R66's Order Summary Report dated 5/9/16, included diagnoses of unspecified intellectual disabilities, impulse disorder, conduct disorder and anxiety disorder. R66's care plan dated 3/11/16, indicated R66 had an alteration in cognitive status related to a diagnosis of mental retardation. R66's Evaluative Report Level II PASRR indicated R66 was evaluated on 8/8/14. R66's proposed date of admission to the facility was 2/3/11. The Level II PASRR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASRR further indicated "This person does require active treatment. The	21510		

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21510	Continued From page 89 local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." R66's medical record lacked an individual service plan (ISP) by the local agency. When interviewed on 5/12/16, at 7:54 a.m. the medical record coordinator stated that R66's Level II PASRR was accepted as it was from R66's previous facility and that the county does not repeat Level II PASRR's unless the resident had been placed back into a community setting. When interviewed on 5/12/16, at 8:37 a.m. licensed social worker (LSW)-B verified that R66's PASRR was completed on 8/8/14 and did not have an annual review. LSW-B stated to determine individual services the facility waited to see what issues the resident had and then made a referral to psychiatry. In addition, medications were reviewed by the interdisciplinary team (IDT) committee for appropriate medications. LSW-B stated currently staff was directed to set boundaries and redirect R66 when inappropriate. On 5/12/16, at 12:35 p.m. LSW-B verified the facility did not have a current ISP and stated that R66 does not have an ISP because he resided in a nursing facility and not a group home setting. On 5/13/16, at 9:36 a.m. the LSW-B stated that he had contacted the county today and R66's did not have an active social worker with the county and did not have an active ISP. The county was updating their software. LSW-B further stated R66 was last assessed by the county in 2015 and the facility did not have the most recent assessment on file. LSW-B had requested a copy	21510		

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21510	Continued From page 90 from the county. The county faxed the most recent Evaluative Report Level II PASRR to the facility, which indicated R66 was re-evaluated on 7/1/15. R66's proposed date of admission to the facility was 2/3/11. The Level II PASRR was completed by Hennepin County and indicated R66 had mental retardation and R66's medical needs required nursing facility services. The Level II PASRR further indicated "This person does require active treatment. The local agency assures that all active treatment needs have been specified in this person's individual service plan and will be met while this person resides in the nursing facility." No ISP was included in the information from the county. A policy for Level II PASRR was requested and none was provided by the facility. SUGGESTED METHOD FOR CORRECTION: The director of social services (SSD) could develop and implement policies and procedurse related to residents with Level II PASRR screenings to ensure active treatment needs are met. The SSD could educate all appropriate staff. The SSD could monitor all residents with a Level II PASRR screening to ensure needs were met and report results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21510		