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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9Q5I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00443

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245463**
2.STATE VENDOR OR MEDICAID NO.
(L2) **707342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER CARE CENTER**
(L4) **1131 SOUTH MABELLE AVENUE**
(L5) **FERGUS FALLS, MN** (L6) **56537**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/18/2016** (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)
09/30

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

12.Total Facility Beds **105** (L18)
13.Total Certified Beds **105** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Denis Erickson, HFE NEII
Date : 03/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath
Enforcement Specialist
Date: 05/03/2016 (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
04/11/1987
(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
03/14/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245463

May 3, 2016

Ms. Sara Watkins, Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, Minnesota 56537

Dear Ms. Watkins:

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 March 1, 2016 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 24, 2016

Ms. Sara Watkins, Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, Minnesota 56537

RE: Project Number S5463026

Dear Ms. Watkins:

On February 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On March 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 25, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 28, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 28, 2016, effective March 1, 2016 and therefore remedies outlined in our letter to you dated February 15, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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
245463 Y1	A. Building B. Wing Y2	3/18/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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 F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0279	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	03/01/2016	LSC	03/01/2016	LSC	03/01/2016
ID Prefix F0282	Correction	ID Prefix F0314	Correction	ID Prefix F0323	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed
LSC	03/01/2016	LSC	03/01/2016	LSC	03/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GA/mm	03/24/2016	31256	03/18/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/28/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245463	A. Building 03 - SOUTH BLDG 3 B. Wing	2/25/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 02/18/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	**REVIEWED BY (INITIALS)** TL/mm	**DATE** 03/24/2016	**SIGNATURE OF SURVEYOR** 36536	**DATE** 03/25/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 1/26/2016	[ ] 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: 9Q5I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00443

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245463**

2.STATE VENDOR OR MEDICAID NO.
(L2) **707342900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PIONEER CARE CENTER**
(L4) **1131 SOUTH MABELLE AVENUE**
(L5) **FERGUS FALLS, MN** (L6) **56537**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/28/2016** (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)
09/30

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

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Sherri Softing, HFE NEII — 03/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 03/10/2016 (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
04/11/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 15, 2016

Ms. Sara Watkins, Administrator
Pioneer Care Center
1131 South Mabelle Avenue
Fergus Falls, Minnesota 56537

RE: Project Number S5463026

Dear Ms. Watkins:

On January 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G).

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 8, 2016 the following remedy will be imposed:

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

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 remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 28, 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 July 28, 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(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.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		3/1/16

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

Electronically Signed | 02/19/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245463	A. BUILDING _____ B. WING _____	01/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

(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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the administrator, immediately report to the State Agency (SA), and failed to conduct a thorough investigation for 1 of 1 residents (R55) who alleged abuse in the facility. Findings include: R55's quarterly Minimum Data Set (MDS) dated 1/5/16, identified R55 was cognitively intact and required assistance with activities of daily living (ADLs). The MDS identified R55 had diagnoses which included Parkinson's disease, anxiety and depression. Further, the MDS identified R55 had no behaviors or signs of delirium. R55's care plan revised 1/11/16, identified R55 needed a safe environment. The care plan also identified R55 had impaired cognitive function/dementia or impaired thought processes	F 225	1) R 55 and R 64 a thorough investigation has been completed by the Administrator, Director of Nursing, and Social Services Director according to facility policy and procedure regarding the 12/6/15 and 1/26/16 allegations. 2) All residents were reviewed; all residents residing at Pioneer Care are Vulnerable Adults, all residents have the potential to be affected by this. All alleged violations involving mistreatment and misappropriation of resident property are reported to state agency and administrator and investigated following facility Abuse Prevention Plan. 3) Facility□s Abuse Prevention Plan was reviewed which included, 1) Screening potential hires; 2) Training of employees (both for new employees and ongoing	

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F 225	Continued From page 2 related to disease processes of Parkinson's disease and R55 had received anti-depressant and anti-anxiety medication and was monitored for side effects. On 1/25/16, at 10:30 a.m. review of an email sent to the facility by family member (FM)-A revealed the facility social worker (SW), director of nurses (DON) and clinical coordinator (CC-A) had received a report via email by R55's family member on 12/6/15. The report identified R55 had reported allegations of sexual abuse regarding a male visitor and R64, and between some staff members. FM-A had requested the facility investigate the allegation made by R55. On 1/25/16, at 2:05 p.m. DON stated she was aware of the 12/6/15, allegations of sexual abuse made by R55 a little bit, but stated she could not remember anything specific about the allegations. She stated she did not know if an incident report had been completed, or if the was documentation regarding R55's allegations. She also didn't know if the allegations had been reported to the SA or the administrator. DON stated the SW investigated the allegations but was unsure of what had been done. DON indicated with these type of allegations the facility would investigate the allegations first and then report to the administrator and SA. DON stated they should have reported the allegations first to the SA, and then investigated after the report had been done. She stated if staff were identified in the allegations they would sometimes suspend the staff member. DON stated she was unsure of what their policy directed them to do. On 1/25/16, at 2:10 p.m. administrator stated she was not aware of the sexual abuse allegations	F 225	training for all employees); 3) Prevention policies and procedures 4) Identification of possible incidents or allegations which need investigation; 5)Investigation of incidents and allegations 6)Protection of residents during an investigation 7) Reporting of incidents and investigations to state agency, and facility response to the results of the investigations and 8) Timely reporting to the Administrator and state agencies of incidents and allegations. The Accidents and Incidents Policy was reviewed and updated, stating the Incident Accident form will be submitted to the Director of Nursing or her designee. The Abuse Prevention Plan, and Accident and Incident Policy will be reviewed with all staff on Feb 26th and 29th,2016. Additional training will be conducted with all licensed nursing staff, social workers, and Administrator on Feb 26th and 29th, 2016 regarding reporting to state agency and administrator, thorough investigations of incidents and allegations, and prevention of further abuse while the investigation is in process. 4) The Director of Nursing and or designee will conduct audits, of incident reports, to ensure all incidents of potential resident abuse are being reported to the state agency and administrator, incidents and allegations are thoroughly investigated, and the facility prevents further abuse while the investigation is in process. Audits will also be conducted of	

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F 225	Continued From page 3 reported by R55. She stated she would expect any allegations of sexual abuse to be reported immediately to the SA and the administrator. She confirmed they should have reported the allegations first and then investigated. On 1/25/16, at 2:27 p.m. SW stated she was aware of the allegations made by R55 on 12/6/15. She stated she did not report the allegations to the SA because she just didn't, and after she investigated, staff and R64 denied the abuse she decided there was no abuse. She confirmed there was not an incident report for R55's allegations but there should have been progress notes. SW stated they typically instruct staff to make their best judgement and decide if they should report an incident or allegation or not. On 1/26/16, at 1:32 p.m. R55 was interviewed in the presence of her healthcare power of attorney (POA). POA stated after R55 reported the sexual abuse allegations to her and 2 other family friends they reported R55's sexual abuse allegations to R55's daughter. R55's daughter contacted the SW, DON and CC-A via email to report the allegations on 12/6/15. R55 stated she had observed staff having sexual relations with a resident and with each other many nights over a period of time. She stated it started immediately after she was admitted to the nursing home. She stated the most recent sexual relations happened the night before last between a male staff person and a female resident. The POA stated the SW's reply to R55's daughter in December was, "Your mom doesn't want to give us names, so there is not much we can do." On 1/26/16, at 5:00 p.m. during follow up interview of R55 with her POA, R55 stated the	F 225	documentation to identify any unreported incidents, as well as staff interviews. Random audits will occur weekly for one month, then monthly for three months. Results of audits will be reported to the Quality Assurance Committee and follow further recommendations. 5) Corrective Action Completed by March 1st , 2016.	

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F 225	Continued From page 4	F 225		

majority of the sexual relations she reported was between a male staff person and a female resident. R55 stated she was unwilling to identify any staff or resident by name because she was afraid of retaliation. POA stated R55 had confided in her and 2 other family friends in late November-early December that a man came into her room most nights and would engage in sexual relations with her roommate. She stated R55 had also reported staff were engaging in sexual acts among each other during the night. She stated the most recent sexual relations happened the night before last between a male staff person and a female resident. She agreed to surveyor to reporting this most recent allegation of abuse to the facility and indicated the incident of sexual misconduct between a male staff person and a female resident the night before last on the Deerwood unit at 11:30 p.m.

On 1/26/16, at 5:15 p.m. the administrator was notified of sexual misconduct between a staff member and a resident which occurred Sunday evening at 11:30 p.m. on the Deerwood unit.

On 1/27/16, at 2:57 p.m. CC-A stated he received an email in December from R55's daughter indicating R55 had made sexual allegations. He stated they talked to R55 and R64 and they didn't really feel like there was anything to investigate. He stated the investigation was closed after talking with R55 and R64. He stated, "I don't know what we would have reported to the SA" and indicated the SW and himself didn't report the allegations to the SA because they felt they didn't have anything to report. He stated VA reporting was something the facility discussed as a team. He stated anytime anything like this comes up there has to be an investigation. He

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F 225	Continued From page 5	F 225		

stated he never discussed the allegations with R55 again and it had never come up again. He stated he didn't know if the SW talked to R55 again, but she was responsible for the social services for R55 and R64.

On 1/27/16, at 3:33 p.m. SW stated she was on the team who investigated the sexual abuse allegations reported to her 12/6/15 and on 1/26/16. She stated they filed a report with the SA for the 1/26/16, allegations and completed the majority of the investigation last night. She stated R64 and nursing assistant (NA)-B were identified in the allegations. She stated NA-B and licensed practical nurse (LPN)-B were assigned to that unit last night. She stated the DON was responsible for contacting NA-B and LPN-B prior to their shift last night. She stated she wasn't sure if the DON talked to them last night or not. She confirmed she revised R55's care plan today and made late entries in both R55's and R64's medical records from the 12/6/15, allegations. She stated when the abuse allegations were made 12/6/15, she felt after she responded to R55's daughter's email on 12/11/15, the investigation was completed. She confirmed printed emails and provided copies. She stated nothing was documented in R55 and R64's medical record because the allegations were not substantiated.

On 1/27/16, at 5:06 p.m. DON confirmed NA-B worked in the facility the previous night shift on the Deerwwod unit with LPN-B. She stated she had not gotten a hold of NA-B before he started his shift because he didn't answer his phone. She stated NA-B worked on Deerwood but not with R55 or R64 because NA-B told her he didn't this morning. She said she allowed NA-B to work during the investigation of the allegation because

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F 225	Continued From page 6 R64 denied the abuse. On 1/27/16, at 7:00 p.m. the chief executive officer (CEO) stated he was aware R55 had identified NA)-B as the alleged perpetrator in the abuse allegations. He stated the facility completed their investigation last night and he felt completely comfortable allowing NA-B to work that night even though NA-B had been identified in the abuse allegation and had not been interviewed regarding the allegations. He stated he felt confident that the allegations were not true because R64 denied the abuse. CEO stated he was aware of the sexual abuse allegations in December. He stated the SW investigated the December allegations and they didn't report the allegations to the SA because the SW was a credible staff person and R64 denied the abuse. He stated he felt the facility did not need to interview any other residents because this was about R55 and R64. CEO stated he felt the facility didn't need to interview NA-B or other staff because the allegation was just not true. He stated he was confident the facility conducted a complete investigation and that R55 was having delusions. He stated R55 also told him groups of people were engaging in sex within the nursing home. The administrator, who was present during the interview, stated the policeman never interviewed R55 or R64 after being called to the facility because the facility told them R64 denied the abuse and he didn't need to. The administrator stated she too felt they completed a thorough investigation and it was completed last night. On 1/28/16, at 8:45 a.m. the social services director (SSD) stated she felt R55's allegations	F 225		

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F 225	Continued From page 7	F 225		

were not reported to the SA in December because they investigated and determined the allegations were not reportable. She stated the allegations were reported now because there were too many unknown variables in the allegations they had to rule out. SSD stated she felt confident with the facility's investigation and stated she felt they did a complete investigation. She stated SW took the lead in December and it was a team decision not to report the allegations of sexual abuse. SSD stated she felt R55 received the appropriate amount of social services support from December until now regarding the allegations. She stated she felt they handled everything correctly. She stated the facility would investigate the allegations and then report to SA after they determined if the allegations were reportable or not.

Review of the Accidents and Incidents policy, revised 2/2014, revealed all accidents or incidents involving residents occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse/and/or the director or supervisor shall compete a Report of Incident/Accident form and submit the original to the DON within 24 hours of the incident or accident, and the DON shall ensure that the administrator receives a copy of the report for each occurrence.

Review of the Abuse Prevention Plan policy, revised 8/1/05, revealed if an incident or suspected incident of abuse, mistreatment, neglect or injury of unknown source be reported immediately to the SA and the administrator notified immediately. The policy further identified a resident incident/accident report must be completed for all accidents or incidents and was

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F 225	Continued From page 8 to include the investigation and results. The policy identified residents shall be protected from harm during an investigation and alleged perpetrators will be suspended during an investigation.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow their Vulnerable Adult Policy related to the immediate reporting to the State Agency (SA), and to conduct a thorough investigation for 1 of 1 residents (R55) who alleged abuse in the facility. Findings include: Review of the Accidents and Incidents policy, revised 2/2014 revealed all accidents or incidents involving residents occurring on our premises shall be investigated and reported to the administrator. The nurse supervisor/charge nurse/and/or the director or supervisor shall compete a Report of Incident/Accident form and submit the original to the DON within 24 hours of the incident or accident, and the DON shall ensure that the administrator receives a copy of the report for each occurrence.	F 226	1) R55 and R 64 a thorough investigation has been completed by the Administrator, Director of Nursing, and Social Services Director according to facility policy and procedure regarding the 12/6/15 and 1/26/16 allegations. 2) All residents were reviewed, all residents residing at Pioneer Care are Vulnerable Adults, all residents have the potential of being affected by this. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported to state agency and administrator and investigated following facility Abuse Prevention Plan. 3) Facility□s Abuse Prevention Plan was reviewed which included, 1) Screening potential hires; 2) Training of employees (both for new employees and ongoing	3/1/16

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F 226	Continued From page 9 Review of the Abuse Prevention Plan policy, revised 8/1/05 revealed if an incident or suspected incident of abuse, mistreatment, neglect or injury of unknown source be reported immediately to the SA and the administrator notified immediately. The policy further identified a resident incident/accident report must be completed for all accidents or incidents and was to include the investigation and results. The policy identified residents shall be protected from harm during an investigation and alleged perpetrators will be suspended during an investigation. R55's quarterly Minimum Data Set (MDS) dated 1/5/16 identified R55 was cognitively intact and required assistance with activities of daily living (ADLs). The MDS identified R55 had diagnoses which included Parkinson's disease, anxiety and depression. Further, the MDS identified R55 had no behaviors or signs of delirium. R55's care plan revised 1/11/16 identified R55 needed a safe environment. The care plan also identified R55 had impaired cognitive function/dementia or impaired thought processes related to disease processes of Parkinson's disease and R55 had received anti-depressant and anti-anxiety medication and was monitored for side effects. On 1/25/16, at 10:30 a.m. review of an email sent to the facility by family member (FM)-A revealed the facility social worker (SW), director of nurses (DON) and clinical coordinator (CC-A) had received a report via email by R55's family member on 12/6/15. The report identified R55 had reported allegations of sexual abuse regarding a male visitor and R64, and between some staff members. FM-A had requested the	F 226	training for all employees); 3) Prevention policies and procedures 4) Identification of possible incidents or allegations which need investigation; 5)Investigation of incidents and allegations 6)Protection of residents during an investigation 7) Reporting of incidents and investigations to state agency, and facility response to the results of the investigations and 8) Timely reporting to the Administrator and state agencies of incidents and allegations. The Accidents and Incidents Policy was reviewed and updated stating the Incident Accident form will be submitted to the Director of Nursing or her designee. The Abuse Prevention Plan and the Accidents and Incidents Policy will be reviewed with all staff on Feb 26th and 29th, 2016. Additional training will be conducted with all licensed nursing staff, social workers, and Administrator on Feb 26th and 29th, 2016 regarding reporting to State agency and Administrator, Thorough Investigations, and prevention of further abuse while the investigation is in process. 4) The Director of Nursing and or designee will conduct audits, of incident reports, to ensure all incidents of potential resident abuse are being reported to the state agency and administrator, incidents and allegations are thoroughly investigated, and the facility prevents further abuse while the investigation is in process. Audits will also be conducted of	

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F 226	Continued From page 10 facility investigate the allegation made by R55. On 1/25/16, at 2:05 p.m. DON stated she was aware of the 12/6/15, allegations of sexual abuse made by R55 a little bit, but stated she could not remember anything specific about the allegations. She stated she did not know if an incident report had been completed, or if the was documentation regarding R55's allegations. She also didn't know if the allegations had been reported to the SA or the administrator. DON stated the SW investigated the allegations but was unsure of what had been done. DON indicated with these type of allegations the facility would investigate the allegations first and then report to the administrator and SA. DON stated they should have reported the allegations first to the SA, and then investigated after the report had been done. She stated if staff were identified in the allegations they would sometimes suspend the staff member. DON stated she was unsure of what their policy directed them to do. On 1/25/16, at 2:10 p.m. administrator stated she was not aware of the sexual abuse allegations reported by R55. She stated she would expect any allegations of sexual abuse to be reported immediately to the SA and the administrator. She confirmed they should have reported the allegations first and then investigated. On 1/25/16, at 2:27 p.m. SW stated she was aware of the allegations made by R55 on 12/6/15. She stated she did not report the allegations to the SA because she just didn't, and after she investigated, staff and R64 denied the abuse she decided there was no abuse. She confirmed there was not an incident report for R55's allegations but there should have been progress notes. SW	F 226	documentation to identify any unreported incidents, as well as staff interviews. Random audits will occur weekly for one month, then monthly for three months. Results of audits will be reported to the Quality Assurance Committee and follow further recommendations. 5) Corrective Action Completed by March 1st, 2016.	

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F 226	Continued From page 11	F 226		

stated they typically instruct staff to make their best judgement and decide if they should report an incident or allegation or not.

On 1/26/16, at 1:32 p.m. R55 was interviewed in the presence of her healthcare power of attorney (POA). POA stated after R55 reported the sexual abuse allegations to her and 2 other family friends they reported R55's sexual abuse allegations to R55's daughter. R55's daughter contacted the SW, DON and CC-A via email to report the allegations on 12/6/15. R55 stated she had observed staff having sexual relations with a resident and with each other many nights over a period of time. She stated it started immediately after she was admitted to the nursing home. She stated the most recent sexual relations happened the night before last between a male staff person and a female resident. The POA stated the SW's reply to R55's daughter in December was, "Your mom doesn't want to give us names, so there is not much we can do."

On 1/26/16, at 5:00 p.m. during follow up interview of R55 with her POA, R55 stated the majority of the sexual relations she reported was between a male staff person and a female resident. R55 stated she was unwilling to identify any staff or resident by name because she was afraid of retaliation. POA stated R55 had confided in her and 2 other family friends in late November-early December that a man came into her room most nights and would engage in sexual relations with her roommate. She stated R55 had also reported staff were engaging in sexual acts among each other during the night. She stated the most recent sexual relations happened the night before last between a male staff person and a female resident. She agreed to surveyor to

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reporting this most recent allegation of abuse to the facility and indicated the incident of sexual misconduct between a male staff person and a female resident the night before last on the Deerwood unit at 11:30 p.m.

On 1/26/16, at 5:15 p.m. the administrator was notified of sexual misconduct between a staff member and a resident which occurred Sunday evening at 11:30 p.m. on the Deerwood unit.

On 1/27/16, at 2:57 p.m. CC-A stated he received an email in December from R55's daughter indicating R55 had made sexual allegations. He stated they talked to R55 and R64 and they didn't really feel like there was anything to investigate. He stated the investigation was closed after talking with R55 and R64. He stated, "I don't know what we would have reported to the SA" and indicated the SW and himself didn't report the allegations to the SA because they felt they didn't have anything to report. He stated VA reporting was something the facility discussed as a team. He stated anytime anything like this comes up there has to be an investigation. He stated he never discussed the allegations with R55 again and it had never come up again. He stated he didn't know if the SW talked to R55 again, but she was responsible for the social services for R55 and R64.

On 1/27/16, at 3:33 p.m. SW stated she was on the team who investigated the sexual abuse allegations reported to her 12/6/15 and on 1/26/16. She stated they filed a report with the SA for the 1/26/16, allegations and completed the majority of the investigation last night. She stated R64 and nursing assistant (NA)-B were identified in the allegations. She stated NA-B and licensed

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practical nurse (LPN)-B were assigned to that unit last night. She stated the DON was responsible for contacting NA-B and LPN-B prior to their shift last night. She stated she wasn't sure if the DON talked to them last night or not. She confirmed she revised R55's care plan today and made late entries in both R55's and R64's medical records from the 12/6/15, allegations. She stated when the abuse allegations were made 12/6/15, she felt after she responded to R55's daughter's email on 12/11/15, the investigation was completed. She confirmed printed emails and provided copies. She stated nothing was documented in R55 and R64's medical record because the allegations were not substantiated.

On 1/27/16, at 5:06 p.m. DON confirmed NA-B worked in the facility the previous night shift on the Deerwwod unit with LPN-B. She stated she had not gotten a hold of NA-B before he started his shift because he didn't answer his phone. She stated NA-B worked on Deerwood but not with R55 or R64 because NA-B told her he didn't this morning. She said she allowed NA-B to work during the investigation of the allegation because R64 denied the abuse.

On 1/27/16, at 7:00 p.m. the chief executive officer (CEO) stated he was aware R55 had identified NA)-B as the alleged perpetrator in the abuse allegations. He stated the facility completed their investigation last night and he felt completely comfortable allowing NA-B to work that night even though NA-B had been identified in the abuse allegation and had not been interviewed regarding the allegations. He stated he felt confident that the allegations were not true because R64 denied the abuse. CEO stated he was aware of the sexual abuse allegations in

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December. He stated the SW investigated the December allegations and they didn't report the allegations to the SA because the SW was a credible staff person and R64 denied the abuse. He stated he felt the facility did not need to interview any other residents because this was about R55 and R64. CEO stated he felt the facility didn't need to interview NA-B or other staff because the allegation was just not true. He stated he was confident the facility conducted a complete investigation and that R55 was having delusions. He stated R55 also told him groups of people were engaging in sex within the nursing home. The administrator, who was present during the interview, stated the policeman never interviewed R55 or R64 after being called to the facility because the facility told them R64 denied the abuse and he didn't need to. The administrator stated she too felt they completed a thorough investigation and it was completed last night.

On 1/28/16, at 8:45 a.m. the social services director (SSD) stated she felt R55's allegations were not reported to the SA in December because they investigated and determined the allegations were not reportable. She stated the allegations were reported now because there were too many unknown variables in the allegations they had to rule out. SSD stated she felt confident with the facility's investigation and stated she felt they did a complete investigation. She stated SW took the lead in December and it was a team decision not to report the allegations of sexual abuse. SSD stated she felt R55 received the appropriate amount of social services support from December until now regarding the allegations. She stated she felt they

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F 226	Continued From page 15 handled everything correctly. She stated the facility would investigate the allegations and then report to SA after they determined if the allegations were reportable or not.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan which included assessed repositioning needs for 1 of 3 residents (R96) reviewed for pressure ulcers. . Findings include:	F 279	1) R 96 expired 2/5/16. 2) All residents Braden scores were reviewed and those who are at risk (Braden score of 15-18 or lower) can be affected by this.	3/1/16

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F 279	Continued From page 16 Review of R96's admission Minimum Data Set (MDS) dated 12/15/15, identified R96 had severe cognitive impairment and had diagnoses which included; femoral fracture, dementia and pressure ulcers. The MDS identified R96 was totally dependent on staff for all activities of daily living (ADL's.) The MDS identified R96 had two stage 1 (observable pressure related alteration of intact skin whose indicators compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temp, tissue consistency, sensation, and or a defined area of persistent redness,) pressure ulcers and two stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister,) pressure ulcers which were present upon admission. The MDS further listed a pressure ulcer intervention of a pressure relieving device for the bed and chair for R96. The MDS did not include a turn and repositioning program for R96. Review of R96's pressure ulcer Care Area Assessment (CAA) dated 12/15/15, identified R96 had two stage 1 pressure ulcers to the buttocks, two stage 2 pressure ulcers, one on each heel and received treatments to the pressure ulcers. The CAA identified R96 was at risk for development of further pressure ulcers and required staff assistance with bed mobility. The CAA further identified R96 required staff assistance with repositioning every 2 hours and as needed (prn.) R96's clinical record lacked documentation of a comprehensive analysis of R96's skin status on	F 279	3) Those residents who are at risk will have tissue tolerance tests completed. Each resident will have their repositioning schedule determined. Care plans will be reviewed and updates as needed with current repositioning schedule. Policy Pressure Ulcer Risk Assessment has been updated to include that a care plan will be developed for a resident at risk of developing a pressure ulcer with appropriate interventions to prevent pressure ulcer from developing. Care Plan will be reviewed with any condition changes and quarterly. Also, the Repositioning Policy has been updated to include the Tissue tolerance test upon admission, and with any change in resident□s status. 4) Nursing staff will be educated on the policy updates Feb 26th and 29th, 2016. Audits will be completed by the DON or designee. Audits include observation of repositioning, and information found on Care Plan. Will complete 4 audits per household per week x 4 weeks. Will also include new admissions as they occur into the audits. After the 4 weeks, random audits will be completed by the DON and/or designee. Results of the audits will be taken to the Quality Assurance committee for further recommendations. 5) Completion date: March 1st, 2016	

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F 279	Continued From page 17 admission. Review of R96's current care plan dated 12/8/15, identified R96 had an actual skin impairment to heels and buttocks. R96's care plan identified R96 required assistance of 2 staff to turn and reposition in bed. However, R96's care plan failed to identify a turn and repositioning schedule. R96's care plan listed various interventions of checking and changing every 2 hours, pressure reducing mattress, apply booties to both feet when in bed and to keep R96's skin clean and dry. On 1/28/16, during continuous observations from 7:59 a.m. to 10:58 a.m., R96 was observed lying in bed on her back without being offered, or assisted to, reposition during the entire observation. - At 7:59 a.m. R96 was observed lying in bed on her back, eyes closed, with a blanket covering up to her neck. R96's bilateral bottom of both feet were uncovered, and black padded boots were observed on both feet. - At 8:52 a.m. R96 remained lying in bed in the same position, on her back with a blanket covering up to her neck. No staff had been observed to enter R96's room. - At 9:10 a.m. R96 remained lying in bed in the same position, on her back with a blanket covering. A housekeeping staff was observed to briefly enter R96's room, to place clothing into the closet and drawers. The housekeeping's staff immediately exited the room, R96 remained in the same position with her eyes closed.	F 279		

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- At 9:45 a.m. R96 remained lying in the same position, on her back, in bed with her eyes open and a blanket covering her. R96 was observed to make no changes in her position independently. No staff had been observed to enter R96's room.

- At 10:17 a.m. R96 continued to lay in bed on her back, eyes open, a blanket covering up to her chin. Nursing assistant (NA)-A was observed walking down the hall outside of R96's room. NA-A looked at R96's room as she walked past, however did not stop or enter R96's room. NA-A was not observed to offer R96 assistance.

- At 10:19 a.m. the certified nurse practitioner (CNP) entered R96's room and approached R96's bed. The CNP briefly spoke with R96 and immediately exited the room. R96 remained in the same position, lying on her back in bed.

- At 10:46 a.m. R96 remained lying in the same position, on her back, in bed, eyes open, a blanket was covering up to her chin.

- At 10:58 a.m. R96 remained on her back in bed. NA-A and NA-E entered R96's room to provide assistance with personal cares. R96 was observed to have pressure ulcer covered with a 4 inch (in) by 8 in absorbent dressing covered R96's sacral area. The dressing had a moderate amount of brown, pungent, foul smelling drainage which had seeped through R96's dressing and onto her brief.

On 1/28/16, at 11:01 a.m. NA-E stated she had assisted R96 to get dressed that morning at 6:45 a.m. and confirmed she had not repositioned R96

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since that time. NA-E stated R96 was unable to reposition herself and required staff assistance for repositioning every 2-3 hours.

On 1/28/16, at 11:03 a.m. LPN- A stated she was aware R96 had black eschar on R96's sacrum on 1/24/16 and a slight odor was also present at that time. LPN-A stated she felt the previous treatment of applying Udder Balm to R96's buttocks had not improved R96's pressure ulcers. LPN-A stated she was unaware of what R96's care plan directed for repositioning, but felt R96 should be repositioned at least every 2 hours to relieve pressure on her sacrum.

On 1/28/16, at 11:04 a.m. NA-A stated she had not repositioned R96 since the beginning of her shift (7:00 a.m.,) and was unsure of when R96 was last repositioned. NA-A stated she thought R96 should be repositioned every 2-3 hours.

R96 had not been repositioned from 6:45 a.m. to 10:58 a.m. a total of 4 hours and 13 minutes.

On 1/28/16, at 11:24 a.m. registered nurse (RN)-A identified R96's stage 1 pressure ulcer on the sacrum had worsened to a stage 4 pressure ulcer and R96's stage 2 pressure ulcer on the left heel had worsened to unstagable pressure ulcer. RN-A confirmed R96's care plan did not include a repositioning plan for R96 and confirmed R96 was not on a current repositioning schedule.

On 1/28/16, at 11:36 a.m. the director of nursing (DON) confirmed she was aware R96's sacral pressure ulcer had worsened from a stage 1 to a stage 4 and stated she was unaware R96 did not have a repositioning schedule in place.

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F 279	Continued From page 20 Review of facility policy titled, Pressure Ulcer treatment revised 2/2014, revealed a purpose of the procedure was to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The policy directed staff to review the residents care plan to assess for any special needs. The policy revealed the pressure ulcers treatment program included, assessing resident and current status of pressure ulcers, current support surfaces, education and quality improvement. The policy revealed a definitions and descriptions of the types of pressure ulcers including, stage 1, stage 2, stage 4 and unstagable. The policy revealed a protocol for individual pressure ulcer stages. The policy directed staff to implement the following interventions for stage 1 pressure ulcers, relieve and redistribute pressure, turn schedule, reduction of friction, shear and incontinence. The policy directs facility staff to notify the physician of a wound did not improve in 2-3 weeks, to re-evaluate nutritional support, off-loading/redistribution devices and wound care products.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document interview, the facility failed to implement the care	F 282	1) R99 expired 2/11/2016	3/1/16

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F 282	Continued From page 21 plan for 1 of 3 resident (R99) reviewed for accidents, and for 1 of 1 residents (R99) at risk for development of pressure ulcers. Findings include: R99's current care plan revised on 9/25/15, indicated R99 was at risk for falls related to de-conditioning, and gait/balance problems. R99's care plan listed various interventions which included chair alarm on the seat of the wheelchair, Wanderguard, use of a baby monitor and indicated R99 may self transfer at times, but was not safe and staff should assist R99 to sit down or use of Hoyer lift as needed to get R99 to a safe place. R99's current nursing assistant care plan provided by the facility listed various interventions which included R99 utilized a chair alarm, and may use a tilt and space wheelchair if really tired, may self transfer at times but is not safe. On 1/27/15, from 11:50 a.m. to 1:17 p.m. R99 was observed in a red tilt and space wheelchair and no chair alarm was observed on R99's chair. At 1:17 p.m. a staff member wheeled R99 back to his room from the dining room and transferred into his bed utilizing a mechanical lift. No alarm was observed in the seat of the wheelchair and no alarm sounded when R99 was lifted from the wheelchair to the bed. On 1/27/16, at 1:22 p.m. nursing assistant (NA)-H and NA-J confirmed R99 had not had an alarm in his tilt and space wheelchair and indicated R99	F 282	2) All residents and their care plans were reviewed by the fall team. Those that have a potential for falls were identified, and can be affected by this. All residents Braden scores were reviewed and those who are at risk can be affected by this. 3)The policy Falls and Fall Risk, Managing was reviewed. This policy states, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. The policy was also updated to state, individualized fall interventions are located on the residents care plan and as needed on the Care Card located in the resident□s closet. Those residents who Braden□s scores indicated at risk of pressure ulcers will have tissue tolerance tests completed. Each resident will have their repositioning schedule determined. Care plans will be reviewed and updated as needed with current repositioning schedule. Repositioning worksheets will be completed by the nursing assistants each shift, and communicated to the oncoming shift the last reposition time for each resident. Staff education will be held Feb 26th and 29th, 2016. This education will review the policy Falls and Fall Risk, Managing and also the Repositioning policy with implementation of repositioning worksheets. 4)The Director of Nursing and/or designee	

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F 282	Continued From page 22 recently started utilizing the tilt and space wheelchair. NA-H indicated R99 had utilized a chair alarm in a regular wheelchair but was unsure if he was supposed to have one in the tilt and space wheelchair. On 1/27/16, during a follow up interview with NA-H and NA-J at 1:54 p.m., they verified R99 was at risk for falls, and was to have a chair alarm on the seat of his tilt and space wheelchair. NA-H indicated the chair alarm had not been transferred from the regular wheelchair to the tilt and space wheelchair and it should of been. NA-H confirmed R99's care plan directed the use of a chair alarm and indicated it was an oversight. On 1/27/16, at 1:35 p.m. licensed practical nurse (LPN)-C confirmed R99 did not had a chair alarm on his tilt and space wheelchair and indicated the facility was "trialing" a different type of wheelchair for R99. LPN-C confirmed R99 had not had the chair alarm in place for the entire morning. She confirmed R99 was at risk for falls and stated, "staff should be using the alarm." On 1/28/16, at 5:07 p.m. director of nursing (DON) confirmed R99's care plan indicated R99 was at risk for further falls and R99 utilized a chair alarm in the wheelchair. The DON stated she would expect staff to have the alarm on R99's wheelchair and would expect the staff to follow the care plan. R99's current care plan dated 7/2/15, identified R99 had impairment to skin integrity related to cyst to buttocks, occasional incontinence, falls and refusal of cares. The care plan directed staff	F 282	will conduct audits by observation of fall interventions, to ensure fall intervention measures for individual residents are implemented according to care plan. Audits will also be completed to ensure compliance of following the residents care plan for timely repositioning by observation of repositioning, and completion of repositioning logs. Audits will be conducted weekly for one month, then monthly for 3 months. Results will be reported to the Quality Assurance Committee, and recommendations given by that team will be followed. 5) Corrective Action Completed by March 1 , 2016	

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to keep skin clean and dry. The care plan listed various interventions which included to clean peri area with each incontinent episode and R99 was able to tolerate repositioning every two hours with no alterations in skin.

Review of R99's current nursing assistant care plan, provided by the facility, directed staff to monitor, document and report any changes in skin breakdown, assist with one staff to turn and reposition in bed, to use disposable briefs, change as needed, clean peri area after each incontinent episode.

On 1/27/16, at 1:17 p.m. R99 was observed seated in a red tilt and space wheelchair at the dining room table, when NA-H and NA-J wheeled R99 back to his room and proceeded to assist R99 from the wheelchair to his bed via total mechanical lift. NA-H checked R99 to see if he was incontinent of bowel and bladder and NA-H stated he was dry. NA-H asked R99 "how he would like to lay" and he did not respond to her. NA-H and NA-J proceeded by positioning R99 on his back laying on a white cloth pad underneath him, then placed a pillow on his upper right side of his body and upper left side, head of bed slightly elevated approximately 30 degrees, bed in low position, call light placed, bed alarm functioning, covered with a blanket which came up to his mid chest area, video monitor in place, and at 1:23 p.m. NA-H and NA-J exited the room.

At 4:14 p.m. NA-K and NA-I entered R99's room and proceeded to assist R99 with incontinence care. NA-K and NA-I indicated R99's incontinent product was wet with urine and soiled with stool and proceeded to change his incontinent product. At 4:18 p.m. NA-K provided peri cares to R99's

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scrotal area which was bright red and shiny in color.

At 4:20 p.m. NA-K and NA-I rolled R99 to his left side and NA-I proceeded by cleaning up R99's rectal/buttocks which had soft brown stool all over it which extended up underneath R99's dressing that he had on his right upper buttocks area. During the observation R99's buttocks was noted to be slightly red around the rectal area which extended to the outer edges of his buttock crease with no open areas noted.

R99 had not been repositioned from 1:17 p.m. until 4:20 p.m., a total of 3 hours and 3 minutes. R99 was unable to reposition himself independently and was not assisted by staff to be repositioned every two hours per his current care plan and had not been checked or changed for incontinence as directed by the care plan.

On 1/27/16, at 7:33 p.m. NA-I confirmed R99's care plan directed R99 was to be repositioned every two hours. NA-I indicated she was unaware when R99 had last been repositioned or checked or changed and stated "he was in bed when I got here and I went in when you watched me."

On 1/27/16, at 7:39 p.m. NA-K confirmed R99 needed to be repositioned every two hours. NA-K indicated day shift reported to her that R99 had last been repositioned around 2:00 p.m.. NA-K verified R99 was to be repositioned every two hours due to pain he has on his buttocks area from his cyst and stated, "I was misinformed, he was getting antsy from watching him on the monitor, so we went in there to get him up." NA-K also stated, "I did not realize that he had not been repositioned for more than two hours and I did not

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F 282	Continued From page 25 repo him prior to us getting him up for supper." On 1/28/16, at 8:32 a.m. registered nurse (RN)-C confirmed R99 was routinely incontinent of bowel and bladder and needed to be checked/changed and repositioned every two hours. RN-C also verified R99's care plan and stated "I would expect staff to follow the care plan and to make sure the resident is be repositioned every two hours." On 1/28/16, at 9:26 a.m. NA-H confirmed R99 was routinely incontinent of bowel and bladder and needed to be checked/changed and repositioned every two hours. NA-H also verified that she did not reposition R99 and stated "we did not reposition him we only adjusted the bed alarm." NA-H stated "it is so painful for him to reposition, we try not to mess with him too much." 1/28/16 at 5:07 p.m. director of nursing confirmed R99's care plan and verified he was to be repositioned every 2 hours and was routinely incontinent of bowel and bladder and needed to be checked/changed. The DON stated she would expect staff to reposition R99 every two hours and follow the care plan. Review of facility policy titled, Care Plans-Comprehensive, revised on 9/2010, indicated an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs is developed for each resident. Our facility develops and maintains a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expect to attain.	F 282		

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F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess, develop and implement interventions to promote healing, prevent the worsening of pressure ulcers for 1 of 3 residents (R96) reviewed for pressure ulcers. This deficient practice resulted in actual harm for R96 who developed worsening pressure ulcers. In addition,the facility failed to implement interventions to prevent the development of pressure ulcers for 1 of 5 residents (R99) identified at risk for the development of pressure ulcers. Findings include: Review of R96's admission Minimum Data Set (MDS) dated 12/15/15, identified R96 had severe cognitive impairment and had diagnoses which included: femoral fracture, dementia and pressure ulcers. The MDS identified R96 was totally dependent on staff for all activities of daily living (ADL's.) The MDS identified R96 had two stage 1 pressure ulcers (observable pressure	F 314	1)R 96 expired 2/5/16 and R 99 expired 2/11/16 2) All resident□s Braden scores were reviewed and those who are at risk (Braden score of 15-18 or lower) and with present skin alterations can be affected by this. Those residents who are at risk and/or present skin alterations will have tissue tolerance tests completed. Each resident will have their repositioning schedule determined. Care plans will be reviewed and updated as needed with current repositioning schedule. 3) A comprehensive skin assessment will be completed upon admission , weekly for the first four weeks after admission for each resident at risk, then quarterly, or whenever there is a change in cognition or functional ability. Policy Pressure Ulcer Risk Assessment reflects these changes.	3/1/16

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F 314	Continued From page 27 related alteration of intact skin whose indicators compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temp, tissue consistency, sensation, and or a defined area of persistent redness,) and two stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister,) which were present upon admission. The MDS further listed a pressure ulcer intervention of a pressure relieving device for the bed and chair for R96. The MDS did not include a turn and repositioning program for R96. Review of R96's pressure ulcer Care Area Assessment (CAA) dated 12/15/15, identified R96 had two stage 1 pressure ulcers to the buttocks, two stage 2 pressure ulcers, one on each heel and received treatments to the pressure ulcers. The CAA identified R96 was at risk for development of further pressure ulcers and required staff assistance with bed mobility. The CAA further identified R96 required staff assistance with repositioning every 2 hours and as needed (prn.) R96's clinical record lacked documentation of a comprehensive analysis of R96's skin status on admission. Review of R96's current care plan dated 12/8/15, identified R96 had an actual skin impairment to heels and buttocks. R96's care plan identified R96 required assistance of 2 staff to turn and reposition in bed. However, R96's care plan failed to identify a turn and repositioning schedule. R96's care plan listed various interventions of	F 314	Nursing assistants will complete repositioning worksheets each shift. Times will be communicated to oncoming shifts of the last time the residents were repositioned to ensure continuity of care. Charge Nurse and Clinical Coordinator will review these worksheets each shift for compliance. All nursing staff will attend in-service training to include the importance of following the resident□s care plan for timely repositioning. In-service will include education on pressure ulcer prevention and repositioning policy will be reviewed. This will in-service will occur February 26th and 29th , 2016. The Licensed Staff will received education on wound assessment and documentation on Feb. 23rd, 2019. 4) Quality Assurance audits will be done to ensure compliance of completing comprehensive skin assessments on admit and then weekly for the first four weeks after admission. These audits will be conducted on the residents record including, skin assessments, bradens scale, comprehensive note in progress notes, and care plans. Audits will be completed weekly for 4 weeks, then randomly by DON and/or designee. Quality Assurance audits by observation, and review of care plan, will be done to ensure compliance of following the residents care plan for timely repositioning and completion of the repositioning logs. These audits will be done weekly on each household x 4 weeks, then randomly by DON and/or designee. Results of the audits will be taken to the Quality	

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F 314	Continued From page 28 checking and changing every 2 hours, pressure reducing mattress, apply booties to both feet when in bed and to keep R96's skin clean and dry. On 1/27/16, at 4:30 p.m. registered nurse (RN)-B stated she felt R96's two stage 2 pressure ulcers had significantly worsened within the last week. RN-B stated she had set up an appointment for R96 to be seen at a wound clinic almost two weeks ago when R96's buttocks pressure ulcer had developed eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound,) tissue on the ulcer. RN-B indicated R96 was seen at the wound clinic on 1/21/16, and R96's buttocks ulcer had been debrided (removal of dead or devitalized tissue) at that time. RN-B confirmed R96 had been diagnosed with one stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling,) to the sacrum. RN-B stated R96 needed staff assistance with repositioning every 2 hours to aid in pressure relief of the sacrum. RN-B stated the only treatment to R96's bilateral heel pressure ulcers were to wear pressure relieving boots. On 1/28/16, during continuous observations from 7:59 a.m. to 10:58 a.m., R96 was observed lying in bed on her back without being offered, or assisted to, reposition during the entire observation. - At 7:59 a.m. R96 was observed lying in bed on	F 314	Assurance Committee for further recommendations. e) Completion date: March 1, 2016	

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her back, eyes closed, with a blanket covering up to her neck. R96's bilateral bottom of both feet were uncovered, and black padded boots were observed on both feet.

- At 8:52 a.m. R96 remained lying in bed in the same position, on her back with a blanket covering up to her neck. No staff had been observed to enter R96's room.

- At 9:10 a.m. R96 remained lying in bed in the same position, on her back with a blanket covering.

- At 9:45 a.m. R96 remained lying in the same position, on her back, in bed with her eyes open and a blanket covering her. R96 was observed to make no changes in her position independently. No staff had been observed to enter R96's room.

- At 10:17 a.m. R96 continued to lay in bed on her back, eyes open, a blanket covering up to her chin. Nursing assistant (NA)-A was observed walking down the hall outside of R96's room. NA-A looked at R96's room as she walked past, however, did not stop or enter R96's room. NA-A was not observed to offer R96 assistance.

- At 10:19 a.m. the certified nurse practitioner (CNP) entered R96's room and approached R96's bed. The CNP briefly spoke with R96 and immediately exited the room. R96 remained in the same position, lying on her back in bed.

- At 10:46 a.m. R96 remained lying in the same position, on her back, in bed, eyes open, a blanket was covering up to her chin.

- At 10:58 a.m. R96 remained on her back in bed.

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NA-A and NA-E entered R96's room to provide assistance with personal cares. NA-E removed the blanket covering R96 and proceeded to pull down her slacks and checked the front of R96's brief. NA-A assisted to turn R96 onto her left side towards NA-E. NA-E assisted to hold R96 onto her left side while NA-A pulled the back of R96's slacks to expose the brief. NA-A proceeded to remove R96's brief and a moderate amount of brown drainage was on the brief. Upon removal of the brief, a 4 inch (in) by 8 in absorbent dressing was observed covering R96's sacral area. The dressing had a moderate amount of brown, pungent, foul smelling drainage which had seeped through R96's dressing and onto her brief.

- At 11:01 a.m. licensed practical nurse (LPN)-A and RN-A entered R96's room. LPN-A removed the 4 in x 8 in absorbent dressing which covered R96's sacrum. A moderate amount of brown, pungent, foul smelling drainage was observed on the dressing. LPN-A proceeded to remove packing gauze from the inside of the pressure ulcer. The gauze was saturated with brown, pungent, foul smelling drainage. RN-A confirmed R96 had a current stage 4 pressure ulcer on the sacrum and confirmed the odor and drainage. RN-A stated he had not observed R96's stage 4 pressure ulcer since it had been debrided at the wound clinic. RN-A observed and confirmed R96's pressure ulcer which revealed measurements of 4 centimeters (cm) long x 3.5 cm wide x 2 cm deep. RN-A stated R96's pressure ulcer had tunneling present under the edges of the entire ulcer which measured 1.4 cm to 1.8 cm. He stated R96 had necrotic tissue of the surrounding skin on the left side extending out form the opening of the the ulcer. RN-A stated

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R96's stage 4 pressure ulcer had not been open at the time of the last assessment, nor was necrotic tissue noted at the that time. LPN-A proceeded to place fresh packing gauze into R96's sacral pressure ulcer with two gauze pads soaked with normal saline and covered R96's ulcer with an absorbent pad and taped the dressing in place. RN-A removed the pressure relieving black boots from R96's feet. R96's right heel was observed to have a flat, hard, blister which measured 1.5 cm x 1.6 cm with no depth. RN-A stated he felt R96 had a healing stage 2 pressure ulcer on her right heel. R96's left heel was observed to have hard, eschar tissue, surrounded in pink skin, which measured 2.5 cm x 3.0 cm, depth obscured by the eschar tissue. RN-A stated R96 had an unstagable (related to slough or eschar: wound bed cannot be visualized due to the presence of slough or eschar,) ulcer on her left heel. RN-A confirmed R96 left heel had a previous stage 2 pressure ulcer that had worsened to an unstagable ulcer. RN-A confirmed R96's current stage 4 sacral pressure ulcer had also worsened from a stage 1 to a stage 4 pressure ulcer.

On 1/28/16, at 11:01 a.m. NA-E stated she had assisted R96 to get dressed that morning at 6:45 a.m. and confirmed she had not repositioned R96 since that time. NA-E stated R96 was unable to reposition herself and required staff assistance for repositioning every 2-3 hours.

On 1/28/16, at 11:03 a.m. LPN- A stated she was aware R96 had black eschar on R96's sacrum on 1/24/16, and a slight odor was also present at that time. LPN-A stated she felt the previous treatment of applying Udder Balm to R96's buttocks had not improved R96's pressure ulcers.

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LPN-A stated she was unaware of what R96's care plan directed for repositioning, but felt R96 should be repositioned at least every 2 hours to relieve pressure on her sacrum.

On 1/28/16, at 11:04 a.m. NA-A stated she had not repositioned R96 since the beginning of her shift (7:00 a.m.,) and was unsure of when R96 was last repositioned. NA-A stated she thought R96 should be repositioned every 2-3 hours.

R96 had not been repositioned from 6:45 a.m. to 10:58 a.m. a total of 4 hours and 13 minutes.

Review of R96's weekly wound assessments from 12/8/15, to 1/21/16, revealed the following;

-On 12/8/15, identified R96 had been admitted with stage 1 pressure ulcers, one on each buttocks and stage 2 pressure ulcers described as fluid filled blisters, one on each heel. The assessment revealed R96's right buttocks pressure ulcer measured 2.0 cm x 6.0 cm x 0.0, the left buttocks pressure ulcer measured, 2.4 cm x 6.0 cm x 0.0, right heel pressure ulcer measured 1.5 x 1.5 cm x 0.0 and the left heel pressure ulcer measured 5.0 cm x 3.5 cm x 0.0 cm The assessment identified a current intervention of air mattress, cushion to chair and booties. The assessment did not identify R96 was on a turning and repositioning plan.

-On 12/17/15, revealed R96 pressure ulcers were unchanged. The assessment identified R96 had a stage 2 pressure ulcer on the right heel, described as an intact blister with irregular, light brown edges and measured 1.5 cm x 1.6 cm x 0.0 cm. The assessment identified R96 had a stage 2 pressure ulcer on the left heel, described

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as an irregular, intact fluid filled blister and measured 5.0 cm x 4.0 cm x 0.0 cm. The assessment revealed R96's skin surrounding both heel ulcers was intact and normal.. The assessment did not identify R96 was on a turn and repositioning routine.

-On 12/18/15, revealed R96's pressure ulcers were unchanged. The assessment identified R96's right heel stage 2 pressure ulcer was a fluid filled blister and measured 1.5 cm x 1.5 cm x 0.0 cm.. The assessment identified R96's left heel stage 2 pressure ulcer was a fluid filled blister and measured 5.0 cm x 3.5 cm 0.0 cm. The assessment identified R96's right buttocks stage 1 pressure ulcer measured 2.0 cm x 6.0 cm x 0.0 cm R96's left buttocks stage 1 pressure ulcer measured 2.4 cm by 6.0 cm x 0.0 cm. The assessment lacked surrounding skin characteristics and coloring. The assessment did not identify R96 was on a turn and repositioning routine.

-On 12/23/15, identified R96's right heel stage 2 pressure ulcer was a fluid filled blister and measured 1.5 cm x 1.5 cm x 0.0 cm The assessment identified R96's left heel stage 2 pressure ulcer was a fluid filled blister and measured 5.0 cm x 3.5 cm 0.0 cm. The assessment identified R96's right buttocks stage 1 pressure ulcer measured 2.0 cm x 6.0 cm x 0.0 cm R96's left buttocks stage 1 pressure ulcer measured 2.4 cm by 6.0 cm x 0.0 cm. The assessment revealed R96's pressure ulcers had no drainage, no odor and areas were improving;. The assessment did not identify R96 was on a turn and repositioning routine.

-On 1/5/16, identified R96's buttocks pressure

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ulcers had worsened from a stage 1 to stage 2. The assessment identified R96's right buttocks pressure ulcer was a stage 2, measured 2.0 cm x 4.0 cm x 0.0 cm. R96's left buttocks pressure ulcer was a stage 2, measured 2.4 cm x 3.0 cm x 0.0 cm. The assessment revealed R96's stage 2 heel ulcers were fluid filled blisters and measured; right heel 1.5 cm x 1.5 cm x 0.0 cm, left heel measured 5.0 cm x 3.5 cm x 0.0 cm. The assessment indicated the pressure ulcers were healing. (The assessment indicated the pressure ulcers were healing, however, the progress notes indicated R96's pressure ulcers were worsening.)The assessment also revealed R96 had interventions in place of an air mattress and booties in bed. The assessment did not identify R96 was on a turn and repositioning routine.

-On 1/14/16, identified R96's right buttocks stage 2 pressure ulcer measured 2.0 cm x 3.5 cm x 0.0 cm, left buttocks stage 2 pressure ulcer measured 2.4 cm x 3.0 cm x 0.0 cm. The assessment identified R96's right heel stage 2 pressure ulcer was a fluid filled blister and measured 1.5 cm x 1.5 cm x 0.0 cm. R96's left heel stage 2 pressure ulcer was a fluid filled blister and measured 5.0 cm x 3.5 cm x 0.0 cm. The assessment indicated R96's pressure ulcers were improving and revealed interventions had been in place that included air mattress, off loading boots on when in bed and udder balm to areas on bottom. The assessment listed a referral to a wound clinic would be done if no improvement in 2 weeks. The assessment did not identify R96 was on a turn and repositioning routine.

-On 1/21/16, identified R96's right buttocks stage 2 pressure ulcer measured 2.0 cm x 3.5 cm x 0.0

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cm, left buttocks stage 2 pressure ulcer measured 2.4 cm x 3.0 cm x 0.0 cm. The assessment identified R96's right heel stage 2 pressure ulcer was a fluid filled blister and measured 1.5 cm x 1.5 cm x 0.0 cm. R96's left heel stage 2 pressure ulcer was a fluid filled blister and measured 5.0 cm x 3.5 cm x 0.0 cm. The assessment revealed a referral was made to the wound clinic. The assessment did not identify tissue type, surrounding skin and did not reflect the presence of the eschar tissue.

Review of R96's nursing progress notes from 12/8/15, to 1/25/16, revealed the following;

-On 12/8/15, identified R96 had an air mattress and heel protectors in place for identified skin issues.

-On 12/10/15, revealed staff had noted some skin breakdown on R96's left butt cheek proximal to the coccyx area and a cream was applied. The progress note also revealed redness on R96's right heel and a heel protector was in place.

-On 12/11/15, revealed R96 continued to have skin breakdown on the left butt cheek proximal to the coccyx, cream was applied. The progress note also revealed redness on R96's heel, a heel protector was in place.

-On 12/15/15, revealed R96 continued to have blisters on both heels. The note indicated R96 had booties on both feet and an air mattress.

-On 12/22/15, revealed R96's pressure ulcers on the buttocks were open with dark pink surrounding skin with scant amount of bleeding. The note revealed an Allevyn dressing was

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applied to R96's coccyx ulcer which measured 2 cm x 1.7 cm. The note indicated the unit coordinator was informed and treatment was set up to monitor R96's ulcer and to change the dressing every 3 days and as needed. A further note revealed R96 was to wear pillow boots at all times.

-On 1/4/16, revealed R96's dressing was changed to the open areas on the coccyx and noted serous drainage on the old dressing.

-On 1/5/16, revealed R96's dressing was changed to the open areas on the coccyx with serous drainage on the old dressing. The note identified R96's ulcer to the inner coccyx area and right buttocks was dark, had a foul odor and the surrounding skin was dark pink and moist.

-On 1/7/16, identified R96 was seen by the physician with a new order to apply Udder Balm to the coccyx wound as needed and to refer to a wound clinic in 1-2 weeks.

-On 1/17/16, identified R96's coccyx pressure ulcer had black necrotic (eschar) tissue which covered the wound which measured 1.0 cm x 1.5 cm and surrounding skin was pinkish to red in color. The note further indicated other wounds on R96's buttocks had healed except for the coccyx ulcer. The note revealed R96 had a referral on 1/7/16, for the wound clinic in 1-2 weeks if the wound did not improve with Udder Balm cream. A note was placed in a physicians communication book. The note did not indicate if a referral had been made.

R96's clinical record lacked a comprehensive skin reassessment when R96's pressure ulcers

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F 314	Continued From page 37 worsened. -On 1/20/16, identified R96's coccyx pressure ulcer was not healing and an appointment had been made with the would clinic. -On 1/23/16, identified R96's coccyx pressure ulcer had a scant amount of bloody drainage, wound bed was dark black in color and the surrounding skin was firm with redness and swelling. The note revealed R96 exhibited pain with the dressing change. -On 1/25/16, revealed R96 had returned from the wound clinic with a diagnosed stage 4 sacral pressure ulcer. The note revealed R96 was to receive the following treatment to the sacral pressure ulcer; start saline moistened 4 x 4's into wound, change every eight hours, wet to dry and cover with gauze. R96 was to have a ROHO type wheelchair pad, mattress pad and to continue to wear heel boots at all times. The note further revealed R96 had another appointment with the wound clinic for further care. Review of R96's Braden (a tool used to identify risk for skin breakdown/pressure ulcers) scale assessments dated 12/9/15, 12/15/15, 12/22/15 and 12/29/15, identified R96 was at moderate risk for skin breakdown. Review of R96's tissue tolerance test (TTT-tool used to determine skin's ability to withstand pressure and determine appropriate turning and repositioning schedules) dated 12/8/15, identified R96's skin was normal on the buttocks after 2	F 314		

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hours of lying. The TTT while sitting entry was dated 12/12/15, identified R96 had no redness on the buttocks at 2 hours. The TTT revealed a third entry dated 12/25/15, identified R96's skin was normal on the buttocks after 2 hours of lying. A fourth entry undated, identified R96's skin was pink/red after lying for 3 hours. The TTT did not identify an analysis of R96's TTT results and did not identify R96's repositioning needs. The form also indicated R96's care plan had not been updated to include a routine repositioning schedule.

Review of R96's physician correspondences from 12/18/15 to 1/20/16 revealed the following;

-A resident fax condition report to physician dated 12/18/15, revealed R96's physician had been notified of stage 2 pressure ulcers on both heels. The fax lacked notification of R96's buttocks pressure ulcers.

-A podiatry clinic referral dated 12/22/15, identified R 96 had decubitus ulcers of the heels with the left ulcer greater then right ulcer, the left ulcer measured 3.5 cm x 4.0 cm and the right ulcer measured 1.6 cm x 1.9 cm. The note indicted R96 was to wear pressure relieving boots at all times.

-A physician progress note dated 1/7/16, identified R96 had ulcers on both heels and coccyx areas. The note revealed R96's heels were improving and R96's coccyx was worsening. The note revealed R96's coccyx ulcer was to be treated with Udder Balm cream as needed and a referral for the wound clinic in 1-2 weeks if no improvement with the udder balm.

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F 314	Continued From page 39 -A wound physician progress note dated 1/25/16, identified R96 had a stage 4 sacral pressure ulcer which required full thickness debridement of necrotic tissue. The progress note further revealed R96's sacral pressure ulcer measured 4.0 cm x 4.0 cm x 2.0 cm and had a moderate amount of odorous, green drainage. The progress note revealed R96 was to receive wet to dry dressing changes every 8 hours and R96 was to return in one week for further debridement. On 1/28/16, at 11:24 a.m. RN-A verified R96's sacral pressure ulcer had worsened since R96's admission. RN-A identified R96's stage 1 pressure ulcer on the sacrum had worsened to a stage 4 pressure ulcer and R96's stage 2 pressure ulcer on the left heel had worsened to unstagable pressure ulcer. RN-A stated the floor nurses who completed the daily treatment for R96's pressure ulcers were expected to notify him of any changes between weekly assessments. RN-A confirmed he had completed weekly wound assessments on R96's pressure ulcers since admission. RN-A confirmed the last wound assessment he had completed for R96 was on 1/21/16. RN-A indicated he had observed R96's pressure ulcers at the time of the weekly assessments. RN-A confirmed R96's care plan did not include a repositioning plan for R96 and confirmed R96 was not on a current repositioning schedule. RN-A stated R96 was unable to independently reposition herself and indicated he usually waited for staff nurses to complete a TTT, then he would determine the repositioning program/schedule. RN-A stated he had just received the results of R96's TTT results that day. RN-A stated the results of the TTT had	F 314		

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indicated R96 required assistance with repositioning every 2 hours. RN-A confirmed no new pressure relieving interventions had been put into place for R96 since the pressure ulcers had worsened. RN-A listed various tasks he was responsible for which included, admissions(30 admissions in the last year), assessments and care planning. RN-A did not provide an explanation for the discrepancies of R96's pressure ulcers found in R96's weekly wound assessments and R96's progress notes.

On 1/28/16, at 11:36 a.m. the director of nursing (DON) stated she felt it was unacceptable for R96 to lay on her back for over 3 hours with a stage 4 sacral pressure ulcer. The DON stated she expected staff to implement new interventions when R96's pressure ulcers had worsened. The DON confirmed she was aware R96's sacral pressure ulcer had worsened from a stage 1 to a stage 4 and stated she was unaware R96 did not have a repositioning schedule in place. The DON stated she expected R96's pressure ulcers to have been reassessed when they worsened and that the nurse manager should be notified of any and all changes with R96's pressure ulcers.

On 1/28/16, at 2:01 p.m. a phone interview was conducted with R96's wound physician (MD.) The MD stated he had last evaluated R96 on 1/25/16, when she had presented at the clinic with a sacral unstagable pressure ulcer. The MD stated R96's stage 4 sacral pressure ulcer had liquefaction necrosis (the soft tissue surrounding R96's sacral bone had liquefied,) underneath a rib of eschar tissue which had covered the pressure ulcer. The MD stated he had opened and debrided the ulcer. The MD stated he felt R96's would have opened sooner or later due to the liquefaction of the soft

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tissue. The MD stated R96's pressure ulcer depth was down to the sacral bone, required future debridment's and routine wet to dry packing's. The MD stated R96's sacral ulcer was caused by pressure which caused the soft tissue around the sacrum to liquefy. The MD also stated with continued unrelieved pressure, R96's sacrum soft tissue would continue to liquefy. The MD stated he felt R96 should be routinely repositioned to prevent pressure on her sacrum.

Review of facility policy titled, Pressure Ulcer treatment revised 2/2014, revealed a purpose of the procedure was to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The policy directed staff to review the residents care plan to assess for any special needs. The policy revealed the pressure ulcers treatment program included, assessing resident and current status of pressure ulcers, current support surfaces, education and quality improvement. The policy revealed a definitions and descriptions of the types of pressure ulcers including, stage 1, stage 2, stage 4 and unstagable. The policy revealed a protocol for individual pressure ulcer stages. The policy directed staff to implement the following interventions for stage 1 pressure ulcers, relieve and redistribute pressure, turn schedule, reduction of friction, shear and incontinence. The policy directs facility staff to notify the physician of a wound did not improve in 2-3 weeks, to re-evaluate nutritional support, off-loading/redistribution devices and wound care products.

Review of a facility policy titled, Pressure ulcers/skin breakdown revised 2/2014, directed

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F 314	Continued From page 42 facility nursing staff to complete a thorough assessment which was to include; the location, stage, length, width and depth, presence of exudates or necrotic tissue, pain presence, residents mobility status, current treatment and interventions and active diagnoses. Review of a facility policy titled, Repositioning revised 5/2013, revealed a purpose of the procedure was to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort, prevent skin breakdown, promote circulation and provide pressure relief. The policy revealed repositioning was critical for residents who were immobile or dependent on staff for repositioning. The policy directed staff to evaluate residents skin condition, develop and implement repositioning plans for residents at risk for breakdown, who were immobile and residents with pressure ulcers. The policy directed facility staff to avoid positioning of a resident on an existing pressure ulcer as additional pressure may impede healing. The policy directed staff to reposition residents who were in bed should be on at least every 2 hour repositioning schedule. The policy directed staff to document, monitor and evaluate resident repositioning plans.	F 314		

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R99 who was identified at risk for pressure ulcers did not receive timely repositioning.

R99's significant change MDS dated 11/20/2015, indicated R99 had diagnoses which included non-Alzheimer's dementia, unspecified urinary incontinence and diabetes mellitus. The MDS identified R99 was severely cognitively impaired and required extensive assistance of two staff for transfers, bed mobility, toilet use, limited assistance of one staff for ambulation and extensive assist of one staff for dressing, personal hygiene. The MDS identified R99 was at risk for the development of pressure ulcers and listed various treatments which included pressure reducing device on bed and on chair. Further, the MDS indicated R99 was frequently incontinent of bowel and bladder.

R99's CAA dated 11/20/15, indicated R99 needed extensive assistance with bed mobility and Braden Score indicated R99 was at risk for development of pressure ulcers. The CAA also indicated R99 needed extensive assistance with toileting and was frequently incontinent of bowel/bladder, and was offered toileting every two hours and as needed.

R99's Braden Scale for Predicting Pressure Sore Risk form, dated 11/19/15, identified R99 was at risk for the development of pressure ulcers, skin was very moist, spent majority of shift in bed or chair, had a problem of friction and shearing and nutrition was probably inadequate.

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R99's current care plan dated 7/2/15, identified R99 had impairment to skin integrity related to cyst to buttocks, occasional incontinence, falls and refusal of cares. The care plan directed staff to keep skin clean and dry. The care plan listed various interventions which included to clean peri area with each incontinent episode and R99 was able to tolerate repositioning every two hours with no alterations in skin.

Review of R99's current nursing assistant care plan, provided by the facility, directed staff to monitor, document and report any changes in skin breakdown, assist with one staff to turn and reposition in bed, to use disposable briefs, change as needed, clean peri area after each incontinent episode.

During observation on 1/27/16 at 1:17 p.m. R99 was observed seated in a red tilt and space wheelchair at the dining room table, when nursing assistant (NA)-H and NA-J wheeled R99 back to his room and proceeded to assist R99 from the wheelchair to his bed via total mechanical lift. NA-H checked R99 to see if he was incontinent of bowel and bladder and NA-H stated "he was dry." NA-H asked R99 "how he would like to lay" and he did not respond to her. NA-H and NA-J proceeded by positioning R99 on his back laying on a white cloth pad underneath him, then placed a pillow on his upper right side of his body and upper left side, head of bed slightly elevated approximately 30 degrees, bed in low position, call light placed, bed alarm functioning, covered with a blanket which came up to his mid chest area, and video monitor in place, at 1:23 p.m. NA-H and NA-J exited the room.

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F 314	Continued From page 45 At 1:52 p.m. NA-H and NA-J entered R99 room due to call light going off, NA-H turned call light off and NA-H stated "bed alarm was going off, we adjusted the bed alarm" then exited the room, R99 continued to lay on his back, with a pillow positioned on his upper right side of his body and upper left side, head of bed slightly elevated approximately 30 degrees, bed in low position, call light placed, bed alarm functioning, covered with a blanket which came up to his mid chest area. NA-H and NA-J did not offer to reposition or assist with toileting for R99. At 2:33 p.m. licensed practical nurse (LPN)-C and another staff member entered R99's room and proceeded to count the narcotics in R99's medication drawer and left the room at 2:34 p.m. R99 continued to lay in the same position on his back, with a pillow positioned on his upper right side of his body and upper left side, head of bed slightly elevated approximately 30 degrees, bed in low position, call light placed, bed alarm functioning, covered with a blanket which came up to his mid chest area. LPN-C and other staff member did not offer to reposition or assist with toileting for R99. At 3:03 p.m. R99's call light was going off, NA-K entered the room and noted R99's elbow rested on the call light pad. NA-K shut call light off and repositioned the call light. R99 continued to lay on his back, with a pillow positioned on his upper right side of his body and upper left side, head of bed slightly elevated approximately 30 degrees, bed in low position, call light placed, bed alarm functioning, covered with a blanket which came up to his mid chest area. NA-K exited the room, and did not offer to reposition or assist with toileting for R99.	F 314		

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At 4:14 p.m. R99 had his right leg slightly hanging off the edge of the bed and continued to lay on his back, with a pillow positioned on his upper right side of his body and upper left side, head of bed slightly elevated approximately 30 degrees, bed in low position, call light placed, bed alarm functioning, covered with a blanket which came up to his mid chest area. LPN-C entered R99's room and stated "he is on the move." NA-K and NA-I also entered R99's room while LPN-C was asking R99 if he was having any pain and he stated "yes on my butt." LPN-C then asked R99 his level of pain by saying "is it crying pain", R99 responded by saying "yes." NA-K and NA-I applied disposable gloves to both hands, removed R99's blanket, then the pillows from the right and left side of his upper body, then pulled his pants down to his knees. NA-K and NA-I indicated R99's incontinent product was wet with urine and soiled with stool and proceeded to change his incontinent product. At 4:18 p.m. NA-K provided peri cares to R99's scrotal area which was bright red and shiny in color.

At 4:20 p.m. NA-K and NA-I rolled R99 to his left side and NA-I proceeded by cleaning up R99 rectal/buttocks which had soft brown stool all over it which extended up underneath R99 dressing that he had on his right upper buttocks area. During the observation R99's buttocks was noted to be slightly red around the rectal area which extended to the outer edges of his buttock crease with no open areas noted.

At 4:31 p.m. NA-I brought in mechanical lift and got R99's red tilt and space wheelchair from bathroom with chair alarm in place to R99's bed. NA-K and NA-I rolled R99 side to side to place lift

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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 314	Continued From page 47	F 314		

sling under R99, then proceeded to assist R99 from his bed to wheelchair via total mechanical lift.

R99 had not been repositioned from 1:17 p.m. until 4:20 p.m., a total of 3 hours and 3 minutes. R99 was unable to reposition himself independently and was not assisted by staff to be repositioned every two hours per his current care plan and had not been checked or changed for incontinence as directed by the care plan.

On 1/27/16 at 7:33 p.m. NA-I confirmed R99's care plan directed R99 was to be repositioned every two hours. NA-I indicated R99 was routinely incontinent of bowel and bladder and needed to be checked/changed every 2 hours. NA-I indicated she was unaware when R99 had last been repositioned or checked or changed and stated "he was in bed when I got here and I went in when you watched me."

On 1/27/16 at 7:39 p.m. NA-K confirmed R99 was routinely incontinent of bowel and bladder and needed to be checked/changed and repositioned every two hours. NA-K indicated day shift reported to her that R99 had last been repositioned around 2:00 p.m. NA-K verified R99 was to be repositioned every two hours due to pain he has on his buttocks area from his cyst and stated "I was misinformed, he was getting antsy from watching him on the monitor, so we went in there to get him up." NA-K also stated "I did not realize that he had not been repositioned for more than two hours and I did not repo him prior to us getting him up for supper."

On 1/27/16 at 7:30 p.m. LPN-C confirmed R99 was to be repositioned every 2 hours and was

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	245463	A. BUILDING _____ B. WING _____	01/28/2016

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PIONEER CARE CENTER	1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537

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routinely incontinent of bowel and bladder and needed to be checked/changed every 2 hours. LPN also verified by adjusting R99 bed alarm was not repositioning him and stated "they should of off loaded him to a different position, he was only moved slightly to adjust the pad." LPN-C verified R99's current care plan directed R99 was to be repositioned every 2 hours.

On 1/28/16 at 8:32 a.m. registered nurse (RN)-C confirmed R99 was routinely incontinent of bowel and bladder and needed to be checked/changed and repositioned every two hours. RN-C also verified R99's care plan and stated "I would expect staff to follow the care plan and to make sure the resident is be repositioned every two hours."

1/28/16 at 9:26 a.m. NA-H confirmed R99 was routinely incontinent of bowel and bladder and needed to be checked/changed and repositioned every two hours. NA-H also verified that she did not reposition R99 and stated "we did not reposition him we only adjusted the bed alarm." NA-H stated "it is so painful for him to reposition, we try not to mess with him too much."

1/28/16 at 5:07 p.m. director of nursing confirmed R99's care plan and verified he was to be repositioned every 2 hours and was routinely incontinent of bowel and bladder and needed to be checked/changed. The DON stated she would expect staff to reposition R99 every two hours and follow the care plan.

Review of a facility policy titled, Repositioning revised 5/2013, revealed a purpose of the procedure was to provide guidelines for the evaluation of resident repositioning needs, to aid

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F 314	Continued From page 49 in the development of an individualized care plan for repositioning, to promote comfort, prevent skin breakdown, promote circulation and provide pressure relief. The policy revealed repositioning was critical for residents who were immobile or dependent on staff for repositioning. The policy directed staff to evaluate residents skin condition, develop and implement repositioning plans for residents at risk for breakdown, who were immobile and residents with pressure ulcers. The policy directed facility staff to avoid positioning of a resident on an existing pressure ulcer as additional pressure may impede healing. The policy directed staff to reposition residents who were in bed should be on at least every 2 hour repositioning schedule. The policy directed staff to document, monitor and evaluate resident repositioning plans.	F 314		
F 323 SS=D	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 observation, interview and document interview, the facility failed to ensure fall prevention interventions were implemented to minimize the risk for further falls for 1 of 3 residents (R99) reviewed for accidents.	F 323	1)R99 is Deceased. 2)All residents, and their care plans were reviewed by the fall team, those that have a potential for falls were identified, and can be affected by this.	3/1/16

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F 323	Continued From page 50 Findings include: R99's significant change Minimum Data Set (MDS) dated 11/20/15, identified R99 had diagnoses which included non-Alzheimer's dementia, cancer and diabetes mellitus. The MDS identified R99 had severe cognitive impairment, and required extensive assistance of 2 staff for transfers, bed mobility, and limited assistance of one staff for ambulation. The MDS identified R99 was not steady and only stabilized with staff assistance for moving from seated to standing position, walking, turning around, moving on and off toilet surface to surface transfers. Further, the MDS identified R99 required use of a walker and wheelchair for ambulation. The MDS identified R99 had 2 falls since prior assessment/admission. R99's significant Care Area Assessment (CAA), dated 11/20/15, identified R99 was not steady and only stabilized with staff assistance for moving from seated to standing position, turning around, moving on and off toilet and surface to surface transfers. The CAA also identified R99 had fallen at least one time since prior assessment, and had balance problems with recent falls and frequently tried to self transfer. R99's Risk Assessment for Falls, dated 11/19/15, identified R99 was oriented to place and person only, was moderately agitated and anxious, had fallen in the past 4 weeks, needed assistance and assistive device/help of persons for balance. The assessment identified R99 was at high risk for further falls. No further fall risk assessments were provided by the facility.	F 323	3)The policy Falls and Fall Risk, Managing was reviewed. This policy states, staff will identify and implement relevant interventions to try to minimize serious consequences of falling. The policy was also updated to state, Individualized fall interventions are located on the residents Care Plan and as needed on the Care Card located in the resident closet. Staff education will be held held for all nursing staff on Feb 26th and 29th , 2016. This education reviewed the policy Fall and Fall Risk, Managing. This education includes education on identifying and implementing fall interventions, as well as location of information of individual residents fall interventions. 4)The Director of Nursing and or designee will conduct audits by observation of staff implementing fall interventions, and care plan review, to ensure fall intervention measures, for individual residents, are implemented according to care plan. Random audits will be conducted weekly for one month, then monthly for three months, results will be reported to the Quality Assurance Committee, and recommendations given by that team, will be followed. 5) Corrective Action Completed by March 1st , 2016.	

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R99's current care plan revised on 9/25/15, indicated R99 was at risk for falls related to de-conditioning, and gait/balance problems. R99's care plan listed various interventions which included chair alarm on the seat of the wheelchair, Wanderguard, use of a baby monitor and indicated R99 may self transfer at times, but was not safe and staff should assist R99 to sit down or use of hoyer lift as needed to get R99 to a safe place.

R99's current nursing assistant care plan provided by the facility listed various interventions which included R99 utilized a chair alarm, and may use a tilt and space wheelchair if really tired, may self transfer at times but is not safe.

During observation on 1/27/15, at 11:50 a.m. R99 was observed seated in a red tilt and space wheelchair at a table in the facility dining room. R99 was drinking juice independently, and no chair alarm was observed on R99's chair.

At 12:25 p.m. R99 remained seated at the table, eating the lunch meal. R99 was not observed with a chair alarm on the tilt and space wheelchair.

At 12:31 p.m. R99 remained seated at the dining room table, and began to lean forward and to the left in his wheelchair while he continued to eat his meal. At 12:34 p.m. licensed practical nurse (LPN)-C briefly approached R99 and assisted him to lean back in the wheelchair and left the area. R99 continued to not have a chair alarm on his wheelchair.

At 12:38 p.m. a staff member and LPN-C moved a bedside table next to R99 and placed his plate

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of food items on the table in front of him. The staff member and LPN-C exited the area and R99 continued to consume a piece of cake. No chair alarm was observed on R99's wheelchair.

At 1:17 p.m. a staff member wheeled R99 back to his room from the dining room and transferred into his bed utilizing a mechanical lift. No alarm was observed in the seat of the wheelchair and no alarm sounded when R99 was lifted from the wheelchair to the bed.

On 1/27/16, at 1:22 p.m. nursing assistant (NA)-H and NA-J confirmed R99 had not had an alarm in his tilt and space wheelchair and indicated R99 recently started utilizing the tilt and space wheelchair. NA-H indicated R99 had utilized a chair alarm in a regular wheelchair but was unsure if he was supposed to have one in the tilt and space wheelchair.

On 1/27/16, during a follow up interview with NA-H and NA-J at 1:54 p.m., they verified R99 was at risk for falls, and was to have a chair alarm on the seat of his tilt and space wheelchair. NA-H indicated the chair alarm had not been transferred from the regular wheelchair to the tilt and space wheelchair and it should of been. NA-H confirmed R99's care plan directed the use of a chair alarm and indicated it was an oversight.

On 1/27/16, at 1:25 p.m. R99's family member (FM)-H confirmed he had a lot of falls recently and he got anxious at times. FM-H indicated R99 would attempt to self transfer and stated that is why a monitor was utilized.

On 1/27/16, at 1:35 p.m. LPN-C confirmed R99 had not had a chair alarm on his tilt and space

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F 323	Continued From page 53 wheelchair and indicated the facility was "trialing" a different type of wheelchair for R99. LPN-C confirmed R99 had not had the chair alarm in place for the entire morning. She confirmed R99 was at risk for falls and stated "staff should be using the alarm." On 1/27/16, at 7:33 p.m. NA-I confirmed R99 was at high risk for falls, made attempts to self transfer and utilized chair alarms and bed alarms. On 1/28/16, at 8:32 a.m. registered nurse (RN)-C confirmed R99 was at high risk for further falls and had recently had a lot of falls. RN-C indicated R99 had a recent decline in health but continued to attempt to self transfer at times. LPN-C confirmed R99's current care plan and stated R99 was to have alarms utilized on his bed, recliner and wheelchair. On 1/28/16, at 5:07 p.m. director of nursing (DON) confirmed R99's care plan, confirmed R99 was at risk for further falls and confirmed R99 utilized a chair alarm the wheelchair. The DON stated she would expect staff to have the alarm on R99's wheelchair and would expect the staff to follow the care plan. Review of facility policy titled, Falls and Fall Risk, Managing, revised on 12/07, indicated that based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling or to try to minimize complications from falling.	F 323		

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	245463	A. BUILDING **02 - MAIN BLDG TWO** B. WING _____	**01/26/2016**

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PIONEER CARE CENTER	**1131 SOUTH MABELLE AVENUE FERGUS FALLS, MN 56537**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 02 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Pioneer Care Center 02 Main Building was found 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 18 New Health Care. The facility was surveyed as two buildings. Pioneer Care Center is two buildings built in 2011. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement and Type V (111) construction. Both buildings are fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 2007 edition. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 2007 edition. The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition. The facility has a licensed capacity of 105 beds and had a census of 99 at the time of the survey.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2016

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

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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K 000	INITIAL COMMENTS FIRE SAFETY Building 03 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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pioneer Care Center was not found 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/19/2016

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us or 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. The facility was surveyed as two buildings. Pioneer Care Center is made up of two buildings. Building 02 main building is a 2-story, without a basement and is Type II (111) construction. Building 03 is a 1-story building without a basement, Type V (111). The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 2007 edition. The facility has a complete fire alarm system with smoke detection in the corridors, spaces open to the corridor and all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 2007 edition. The fire alarm is monitored for automatic fire department notification. The sleeping rooms have smoke detection in them and all hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2007 edition.	K 000		

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K 000	Continued From page 2 The facility has a licensed capacity of 105 beds and had a census of 99 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 18.3.7, 18.3.7.1, 18.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the south end of the facility in the event of a fire which could affect 44 of the 105 residents as well as an undetermined number of staff and visitors. Findings include: On facility tour between 9:30 AM to 2:30 PM on	K 025	Cable Pipe Sleeve now has been sealed with the correct fire barrier sealant. Completed on 2/18/2016 Completed by Doug Elliott Environmental Services	2/18/16

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K 025	Continued From page 3 01/26/2015, it was observed that the smoke barrier for the Deerwood wing had a cable pipe sleeve that was found to be passing through the smoke barrier wall without firestopping inside of it. This deficient practice was confirmed by the Environmental Services Director	K 025		