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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B1TG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00122

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245417**

2. STATE VENDOR OR MEDICAID NO. (L2) **516842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROBBINSDALE REHAB & CARE CENTER**
(L4) **3130 GRIMES AVENUE NORTH**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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) **07/01/2015**

6. DATE OF SURVEY **02/01/2016** (L34)

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

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

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

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

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

12.Total Facility Beds **75** (L18)

13.Total Certified Beds **75** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A,5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(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):

CCN 24-5417

Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

17. SURVEYOR SIGNATURE — Date :
Gloria Derfus, Unit Supervisor — 02/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 02/26/2016 (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 **03/01/1987** (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) **00**
VOLUNTARY
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. **06301** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **02/04/2016** (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245417

February 26, 2016

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehab & Care Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

Dear Ms. Pankratz:

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 January 26, 2016 the above facility is certified for:

75 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 75 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 26, 2016

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehab & Care Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: Project Number S5417025

Dear Ms. Pankratz:

On January 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 17, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 22, 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 December 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 26, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 17, 2015, effective January 26, 2016 and therefore remedies outlined in our letter to you dated January 4, 2016, will not be imposed.

Your request for a continuing waiver involving the deficiency cited under K67 at the time of the December 17, 2015 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 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
245417 Y1	A. Building B. Wing Y2	2/1/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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 F0176	Correction	ID Prefix F0257	Correction	ID Prefix F0278	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.15(h)(6)	Completed	Reg. # 483.20(g) - (j)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0314	Correction	ID Prefix F0322	Correction	ID Prefix F0323	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(g)(2)	Completed	Reg. # 483.25(h)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0329	Correction	ID Prefix F0332	Correction	ID Prefix F0333	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.25(m)(1)	Completed	Reg. # 483.25(m)(2)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0371	Correction	ID Prefix F0428	Correction	ID Prefix F0431	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	02/26/2016	18623	2/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245417 Y1	A. Building B. Wing Y2	2/1/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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 F0441	Correction	ID Prefix F0456	Correction	ID Prefix F0465	Correction
Reg. # 483.65	Completed	Reg. # 483.70(c)(2)	Completed	Reg. # 483.70(h)	Completed
LSC	01/26/2016	LSC	01/26/2016	LSC	01/26/2016
ID Prefix F0468	Correction				
Reg. # 483.70(h)(3)	Completed				
LSC	01/26/2016				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	2/26/2016	18623	2/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/17/2015

☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245417 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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 K0066	Correction Completed 01/26/2016	ID Prefix Reg. # NFPA 101 LSC K0067	Correction Completed 01/26/2016	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 2/26/2016	SIGNATURE OF SURVEYOR 19251	DATE 2/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
12/15/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 3020 0001 8869 0725

February 16, 2016

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehab & Care Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

Subject: Robbinsdale Rehab & Care Center - IDR
Provider # 245417
Project # S5417025

Dear Ms. Pankratz:

This is in response to your letter of January 8th, 2016, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F225 and F226 issued pursuant to the survey event B1TG11, completed on December 17, 2015.

The information presented with your letter, the CMS 2567 dated December 17, 2015, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F225, D-S/S 42 CFR § 483.13 Staff Treatment of Residents F225 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, uncluding 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 certifiaction agency.)

F226, D-S/S 42 CFR § 483.13 Staff Treatment of Residents F226 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

Summary of the facility's reason for IDR of this tag.
The facility indicated a report to the State agency (SA) was submitted on 12/17/15, when the facility was notified of R4's allegation of potentital resident to resident abuse. The facility conducted a thorough investigation and the result of the investigation was submitted to the SA within the required 5 working days. On 1/6/16, the facility submitted a copy of a facsimile transmittal sent to facility on

12/18/15, at 6:35 a.m. tracking identification number 90981, which indicated an incident report had been recieved at the Office of Health Facility Complaints (OHFC) and the facility investigative report of the incident was due within 5 working days of the incident. A second facsimile dated 12/23/15, sent to the facility titled Disposition Letter from MDH, indicated the facility had submitted a report of possible maltreatment from the facility on 12/17/15, with a tracking ID of 90981. The facsimile further listed the information submitted had been reviewed and it was determined that no further action by the OHFC was necessary at that time.

Summary of facts: An incident of potential resident to resident abuse was reported by R4 to the survey team during survey. Interviews revealed the facility was not aware of the incident and the director of nursing (DON) was notified of the report. After survey, on 12/21/15, the facility informed the survey team an investigation of the incident had been done, however, the report had not indicated a report of the incident of potentital abuse had been submitted to OHFC prior to initating an investigation. On 1/6/16, the facility sent copies of a facsimile dated 12/18/15, at 6:35 a.m. which indicated an incident had been reported of potentital resident to resident abuse involving R4. In addition, a copy of the investigation done by the facility and a facsimile of submission of the investigation to OHFC was submitted.

This in not a valid example of a deficient practice under these regulations, F225 and F226, and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gail Anderson

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 218-332-5140 Fax: 218-3325196

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Gloria Derfus, Metro Team C Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to ensure 2 of 2 residents (R82, R87) who were assessed not to self-administer medication. Findings include: R82 was observed on 12/14/15, at 7:03 p.m. to have a clear plastic medication cup on the table in front of R82 with four medications in it. There were two blue and white capsules, one dark colored capsule and a white oval that had the word Renvela (prevent hypocalcemia-low levels	F 176	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by January 26, 2016.	1/26/16

REVISED

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

Electronically Signed | 01/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(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 176	Continued From page 1 of calcium in the body) printed on it. There were three other residents seated at the table. The medication cup remained at the table throughout the evening meal until R82 self-administered the medications at 7:25 p.m. Licensed practical nurse (LPN)-D was noted to leave the dining room area at the time of the observation and was not in a location where able to visualize R82. Self-medication and Data Collection and assessment dated 8/31/12, and reviewed 5/11/13, was marked not applicable and indicated resident requested staff to administer medication. Quarterly Nursing Data Collection and Assessment dated 10/5/15, indicated no for "self-medicates/desires to self-medicate." R82's quarterly Minimum Data Set (MDS) dated 10/6/15, indicated R82 was moderately cognitively impaired and had diagnoses of dementia, diabetes and chronic kidney disease stage 4 on dialysis. Nursing Comprehensive Admission Data dated 12/6/15, indicated no for R82 had no desire to self-administer the medication. The Hennepin County Medical Center Discharge orders printed 12/6/15, indicated R82 was to take one Nephrocap (a combination of B vitamins used to treat or prevent vitamin deficiency due to poor diet, certain illnesses) 1 milligram (mg) capsule by mouth in the afternoon, two Phoslo capsules (used to treat high levels of phosphate in patients with chronic renal failure) 667 mg each three times a day with meals and Renvela 800 mg by mouth three times daily with meals.	F 176	A Self Medication and Data Collection and assessment was completed for R82 on 1/5/2016 in order to evaluate R82's ability to safely self-administer her medications. The results were reviewed by the interdisciplinary team (IDT) prior to implementation to determine if the practice is safe. Licensed Practical Nurse (LPN) D was provided education on 12/15/2015 related to self-administer drug management procedure to ensure LPN -D follows correct procedure when administering medications. A Self Medication and Data Collection and assessment was completed for R87 on 1/5/2016 in order to evaluate R87's ability to self-administer her medications. The results were reviewed by the IDT to determine if the practice is safe. LPN-D was provided education on 12/15/2015 related to self-administration management procedure when administering medications. All residents have the potential to be affected by the same deficient practice. A facility wide audit was completed on 12/17/2015 and 19 residents were identified with current self- administration of medications and will be re evaluated by 1/26/2016. Measures and systematic changes made to ensure that the deficient practice will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(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 176	Continued From page 2 There was no physician order or care plan for R82 to self-administer medications. R87 was observed on 12/14/15, at 7:03 p.m. to have a clear plastic medication cup on the table in front of R87 with two white tablets in it. There were three other residents seated at the table. The medication cup remained at the table throughout the evening meal until R82 self-administered the medications at 7:20 p.m. LPN-D was noted to leave the dining room area at the time of the observation and was not in a location where able to visualize R87. On 12/16/15, at 2:07 p.m. a bottle of Nystatin powder (used to treat fungal skin infections) was observed on an end table in R87's room. Self-Medication and Data Collection and Assessment dated 5/10/14, was marked not applicable and indicated resident will allow nursing staff administer medication. Quarterly Nursing Data Collection and Assessment dated 10/27/15, indicated no for "self-medicates/desires to self-medicate." R87's quarterly MDS dated 10/27/15, indicated R87 was severely cognitively impaired and had diagnoses of dementia and heart failure. The Physicians Orders for period December 2015 listed Tylenol Extra Strength (a mild analgesic) 2 caplets (1000 mg) by mouth three times a day. There was no Physician Order for Nystatin powder on order sheets. There was no Physician Order or care plan for R87 to	F 176	not re occure include reviewing new admissions prior to the plan of care (POC) meeting, held within 21 days of admissioni. Current in house residents will be reviewed during the facility weekily comprehensive care plan review meetings per the assigned schedule. All Registered Nurses (RN) and LPN's will be inservice on policy and procedure by 1/26/2016. Audits will be completed weekly x 4 weeks by the DON and/ or designee that will monitor identified residents for the ability to self-administer drugs. The DON and/ or her designee will complete audits with RN's and LPN's related to self-medication. Audits will be reviewed during the quality Assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

(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 176	Continued From page 3 self-administer medications. During interview on 12/15/15, at 11:55 a.m. LPN-D stated, "Yes, I left the pills on the table last night for them. They both like to take their pills with meals. If you give them their pills when they are in their room, they will bring it to the dining room. I do not know if they have self-administration of medication orders." LPN-D verified the medications left for R82 were two Phoslo capsules, on Renvela tablet and one Nephrocap. LPN-D verified the medication left for R87 were two Tylenol 500 mg tablets. On 12/17/15, at 12:28 p.m. registered nurse (RN)-B verified R82 and R87 do not have self-administration orders, assessments or care plans. The nurse should not have left the medications with them. During an interview on 12/17/15, at 2:07 p.m. when asked would you expect nurses to leave a cup of medications on the dining room table for a resident who does not have a self-administration of medication order, the interim director of nurses (IDON) said, "No, they have to have all three: an assessment, an order and a care plan." The IDON verified R82 and R87 could not safely self-administer medications. Self Medication Assessment and Management Procedure dated July 2015, instructed staff: The facility used the Self Medication and Data Collection and Assessment form to evaluate the resident's ability to self medicate safely. "1. Review resident's request to self medicate" and "7. Determine outcome of the assessment.	F 176		

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	245417	A. BUILDING _____ B. WING _____	12/17/2015

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F 176	Continued From page 4 a. Resident able to safely self-administer medications. * All questions must be marked "able" for resident to self-administer b. Resident unable to self-administer medications at this time. Document the reason and plan for re-evaluation as appropriate."	F 176		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure comfortable temperature was maintained in 1 of 3 dining rooms (Three South). This had the potential to affect 25 of 26 residents who used the dining in the unit. Findings include: 3rd floor North dining room On 12/14/15, at 6:30 p.m. to 7:10 p.m. during a dining room observation the dining room was noted to be very warm. At the time of the observation 11 residents were in the dining room (DR) waiting for the food and then they got served. As residents waited for food, R46 and R61 were seated at the far table, close to door and were overheard to state the room was very hot.	F 257	Staff offered to remove the sweater of R61, which was declined. The fan mounted on the wall in the dining room was cleaned immediately during the environmental tour on 12/16/2015. All residents have the potential to be affected. Staff will be in-serviced on actions they can take when residents verbalize concerns related to temperatures, e.g. statements such as, "It's hot in here" by 1/26/2016. The pnuematic thermostats are being re-calibrated to create a more comfortable environment for the residents. Audits will be completed by the Director of Maintenance and/or designee 3 times a week times 2 weeks, then weekly times 2	1/26/16

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F 257	Continued From page 5 On 12/15/15, at 8:25 a.m. during the breakfast meal R165 was overheard to indicate to R13 the DR was hot which was the other side of the split DR. R13 nodded her head as she wiped her forehead with her napkin. R13's Minimum Data Set (MDS) dated 10/22/15, indicated had impaired cognition impairment however, R13 had the ability to express their needs and understand others. R61's Minimum Data Set (MDS) dated 11/25/15, indicated had impaired cognition impairment however, R61 had the ability to express their needs and usually understand others. R165's Minimum Data Set (MDS) dated 12/9/15, indicated had moderate cognition impairment however, R165 had the ability to express their needs and understand others. R13's MDS dated 11/13/15, identified R13 as having intact cognition and was able to express their needs. On 12/16/15, at 7:40 a.m. R61 was observed to have removed her sweater shortly after being brought into the DR for exercises. During the exercises R61 kept dozing on and off and at 7:59 a.m. restorative staff approached asked R61 "You look tired do you want to stay for breakfast or go take a nap" R61 stated "What time is it. It's hot in here." Restorative staff then wheeled R61 to the table offered to remove her sweater completely but R61 stated "Just leave it." On 12/16/15, at 10:37 a.m. to 11:53 a.m. the	F 257	weeks to monitor air temperatures in various locations. The dining room fans will be audited by the housekeeping supervisor or designee to ensure they are cleaned per the cleaning schedule. The results will be reviewed at the monlthly QA meeting to determine if any trends are identified and recommendations made for continued audits/monitoring needs.	

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F 257	Continued From page 6 environmental tour was conducted with the maintenance supervisor (MS), executive director, housekeeping supervisor, executive director in training and housekeeping and laundry manager. During the tour, the DR window had been cracked open. Even with the window cracked open, the temperature reading of the DR was 82.7 degrees. In addition, the other split DR side temperature was reading 81.5 degrees and MS stated it was hard to regulate the temperature in the building with the fluctuating outside temperatures. MS acknowledged the temperature was high. When asked to close the DR window, the MS declined to close the window as there were residents in the DR and MS thought the DR room was "hot." In addition a fan mounted on the wall in the DR was observed to have fluffy gray black matter build-up on the on the fan grates. During the tour the fan was noted to be running and blew air into the dining room directly onto the tables where residents sat during meals. When asked how often the fan was cleaned the housekeeping and laundry manager stated every other month. When asked when the fan in the DR had been cleaned last housekeeping and laundry manager stated she was not sure as the previous manager was responsible for overseeing the cleaning was done. Housekeeping and laundry manager stated she had not been at the facility for three months and thought would have been cleaned in August 2015, last. On 12/16/15, at 11:56 a.m. a copy of the facility policy was requested but not provided.	F 257		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		1/26/16

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F 278	Continued From page 7 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R98) Minimum Data Set (MDS) was coded accurately reviewed for urinary incontinence. Findings include:	F 278	R98 Quarterly MDS ARD dated 10/23 was reviewed on 12/17/2015 and a modification was completed on 1/6/16. Resident was discharged on 11/1/2015. All residents have the potential to be affected by this practice.	

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F 278	Continued From page 8 R98's admission MDS dated 7/25/15, indicated resident had been coded as occasionally incontinent and on the subsequent quarterly MDS dated 10/23/15, had been coded as being frequently incontinent which indicated a decline in bladder continence. The Urinary incontinence Care Area Assessment (CAA) dated 7/27/15, indicated resident had occasional bowel and bladder incontinence since admission, had several aspects that played into it such as being new to facility, had recently had a major surgery and took a diuretic which increased the chance of incontinence. The CAA had also indicated R98 was alert and oriented and was able to ask for assistance and had the potential for independence with toileting as well as continence of bowel and bladder. R98's care plan dated 10/15, identified resident had an alteration in urinary continence. The care plan directed staff to complete care tracker three-day elimination tracking to determine a voiding pattern, complete bladder data collection and assessment among others. R98's diagnoses included arthritis, cerebrovascular accident, abnormal gait, hip joint replacement, and muscular wasting and was obtained from quarterly MDS dated 10/23/15. R98's undated Bladder Data Collection And Assessment indicated resident was continent. and on the undated Bowel Data Collection and Assessment was indicated resident was continent and used a diuretic.	F 278	The IDT will receive the re-education MDS accuracy standards per the RAI manual by 1/26/2016. Re-education will be conducted by the Regional Director of Revenue Integrity and/or designee. The DON and/or designee will educate the nursing staff by 1/26/16 on resident documentation. The Regional Director of Revenue Integrity and/or designee will audit three MDS's per month for a period of three months to validate accuracy. The facility's IDT weekly comprehensive care plan review (CCPR) meeting will be utilized to validate accuracy of MDS coding after the MDS has been completed. Results of audits will be reviewed at the faciity's QA meeting monthly until resolved.	

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F 278	Continued From page 9 On 12/17/15, at 12:52 registered nurse (RN)-E, the MDS coordinator, after she pulled the data used to code the MDS's stated during the admission MDS with assessment dates 7/19/15 through 7/25/15, R98 had three episodes of incontinence during the time frame and that was why he was coded as occasionally incontinent. The quarterly MDS dated 10/23/15, with assessments dates 10/17/15 to 10/23/15, noted R98 to have had six episodes of incontinence which put him to be coded as frequently incontinent. The MDS coordinator stated R98 had a surgery on 10/9/15, and came back to the facility on 10/12/15, and the quarterly MDS was done within two weeks post surgical. When asked about the undated assessment which indicated R98 was continent the MDS coordinator stated she was not sure and acknowledged she had co-signed them and stated was going to follow up with the licensed practical nurse-C if resident had been put on a toileting program. -At 2:34 p.m. the RN-E approached and stated the quarterly MDS had been coded based the data that nursing assistants had documented in care tracker and did not realize it was mistaken data at the time and acknowledged resident was supposed to have been coded as occasionally incontinent as the admission MDS. RN-E acknowledged the quarterly MDS had been coded inaccurately and stated would follow up with the consultant to see if MDS could be modified. -At 3:03 p.m. interim director of nursing (IDON) stated the nurses were supposed to analyze the data and follow up with data and ask questions to make sure the data was accurate if there was a change and then follow up with a notation the	F 278		

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F 278	Continued From page 10 information was accurate. IDON stated the MDS was going to be modified and was going to follow up with the nurse.	F 278		
F 282 SS=E	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 review, the facility failed to ensure the plan of care was implemented for 1 of 3 residents (R91) reviewed for ADL's; for 1 of 3 residents (R14) reviewed for repositioning; for 1 of 3 residents (R72) for standard of tube feeding and for 1 of 3 residents (R61) reviewed for non-pressure related skin issues. Findings include: Shaving: R91 was not shaved according to the plan of care. R91 was observed to be sitting in the wheelchair (w/c) in his room on 12/14/15, at 3:52 p.m. and the resident face was covered with facial hair. When R91 was asked about be shaved, he stated "I shave every morning" and "it disturbed him to be seen by a young lady unshaven." On 12/16/15, at 8:49 a.m. R91 was in the dining room (DR) eating breakfast and still was observed to be unshaven. On 12/17/15, at 7:45	F 282	Shaving: R91 was given extensive assist with his shaving needs on 12/18/2015. A facility wide audit was completed on 12/18/2015 and seventeen male residents are noted to require extensive assist with shaving needs. In-servicing will be provided to all staff by 12/26/2016 that address the need to provide services by qualified persons in accordance with each residents plan of care (POC). Staff in-servicing will also address direct observation and actions to be taken if residents are observed to be unshaven. Audits will be completed by the DON and / or designee that will monitor identified residents requiring assist with shaving three times a week for two weeks, then weekly. The weekly audits will be completed during facility caring partners rounds. Audits will be reviewed during	1/26/16

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F 282	Continued From page 11 a.m. and 1:07 p.m. R91 was seated in the area lounge and remained unshaven. R91's care plan dated 10/25/15, indicated R14 required extensive assist of two with personal hygiene which included combing of hair, shaving, dressing and undressing. On 12/17/15, at 12:43 p.m. registered nurse (RN)-B was interviewed and indicated R91 did not look like he got shaved. R91 did not receive the care and services according to the plan of care for personal hygiene as he remained unshaved from 12/14 15 through 12/17/15. Repositioning: Physician's Order signed 11/30/15, indicated staff were to "Reposition every 2 hours in bed and every 1 hour in chair." R14's Skin Integrity Assessment: Prevention and Treatment Care Plan undated, instruct staff to implement an individualized turning schedule in applicable "q [every] 2 hrs [hours]", to turn R14 on the left side while in bed but not at all times, and to turn R14 with two pillows slightly high on side. W/c positioning per medical doctor (MD) order. R14 was not repositioned every two hours according to the plan of care. On 12/16/15, R14 was observed for repositioning and the following was noted: - At 9:45 a.m. was up in the w/c with speech therapy in DR. - At 10:30 a.m. the resident was her room seated in the w/c. - At 10:45 a.m. the resident in lounge playing dice.	F 282	the QA meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs. Repositioning: R14 elected hospice services and the POC and physician orders were reviewed and updated on 1/5/2016. A facility wide audit was completed on 1/18/2016 with eight residents identified that require assist with repositioning based on physician recommendations. In - servicing will be provided to all nursing staff by 1/26/2016 that addresses need to provide services by qualified persons in accordance with each residents POC. Staff in - serviceing will also include a review of the skin integrity assessment prevention program and treatment POC. Audits will be completed by the DON and/or designee that will monitor identified residents requiring assist with repositioning three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs. G-Tube placement: R72's Orders and POC was reviewed on 12/17/2015 as it relates to G-tube	

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F 282	Continued From page 12 - At 12:17 p.m. R14 was asleep in w/c in DR. - At 12:25 p.m. R14 was awake sitting at the table in the DR. - At 1:32 p.m. R14 was placed in her bed. R14 went for three and 45 minutes without being repositioned. On 12/16/15, at 12:25 p.m. R14 was interviewed and was asked if she had laid down. R14 replied, "I have not been to bed. I did not refuse. I would have preferred to sleep in my bed. I did enjoy the dice game. They said I need to eat." - At 12:30 p.m. nursing assistant (NA)-G was interviewed and stated, "I have not laid her [R14] down yet. - At 12:31 p.m. a second NA was interviewed and NA-H, remarked, "No, I have not laid her down she was playing dice and it is lunch now." - At 1:32 p.m. RN-B, stated, "[R14] did not go to bed between breakfast and just now. We ideally only keep her up a couple of hours at a time. I have not seen her refuse to lay down." On 12/17/15, at 10:38 a.m. NA-I stated R14 would ask for assistance when she needs to use the bathroom facilities. R14 was to be repositioned every two hours from left to right and she did not refuse to bed. - At 10:52 a.m. NA-H stated R14 was to be repositioned every two hours and sometimes when R14 was in the chair the aide(s) would lay her down after meals. - At 12:33 p.m. RN-B stated the wound doctor here and the doctor noted the wound was better. RN-B remarked, "Staff normally turn and reposition her every two hours. She is compliant with turning and reposition. No one came and told me we were having problems." RN-B	F 282	placement, medication administration and nutritional formula tube feeding administration. Resident recieves bolus feedings, which he tolerates without signs or symptoms of adverse affects, to allow him increased independence rather than have a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolus tube feedings, g-tube placement verification and G-tube medication administration on 12/28/2015. A facility wide audit was completed on 12/17/2015 and four residents were identified that have the potential to be affected by this practice. In-servicing will be provided to staff by 1/26/2016 that addresses standards of practice as it relates to G-tubes and tube feedings. Audits will be completed by the DON and/or designee that will monitor identified residents requiring G-tube placement checks, medication and tube feeding administrations, three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs. Skin alteration: An assessment was completed and	

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F 282	Continued From page 13 indicated the wound had been present for over three months. During interview on 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) stated, "A resident who has a stage 4 pressure ulcer [e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers] to be repositioned based on physician recommendations, what is on their MDS and care plan." The IDON stated, "R14 should not have stayed up from 9:45 a.m. to 1:30 p.m. without being repositioned. I would expect staff to follow the care plan and physician orders." G-tube placement: R72's gastrostomy tube (G-tube) was not checked for placement according to the plan of care. R72's medication administration observation and enteral feeding via R72's G-tube was observed from 8:34 a.m. until 9:2[illegible] a.m. RN-D was observed to flush the G-tube with 100 cubic centimeters (cc) of water without first checking placement. RN-D then continued to administer medications via drawing them up into a syringe and pushing them into the G-tube. After administering medications RN-D flushed the G-tube with 50 cc of water and drew up 50 cc of Jevity (a calorically dense nutritional formula for tube feeding) 1.5 with a syringe and pushed it into the G-tube. RN-D repeated that action until 225 cc of Jevity had been given. RN-D flushed the G-tube with 50 cc of water than gave the medication omeprazole (for gastroesophageal	F 282	monitoring was put into place on 12/16/2015 for R61 related to identified non-pressure skin issues. All residents have the potential to be affected by the same practice. Education will be provided to staff as it relates to monitoring and reporting observations to the team member qualified to provide the necessary services by 1/26/2016. Audits will be completed by the DON and/or designee weekly for residents identified to have non-pressure skin issues to ensure monitoring is in place. Audits will be reviewed during the qulity assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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F 282	Continued From page 14 reflux disease-GERD) and flushed the G-tube with 50 cc of water. The Nutrition Risk Care Plan dated 10/8/14, listed as nutritional risk factors were cardiac disease, risk of dehydration, low sodium levels, R72 typically consumed approximately 10 percent (%) of meals, swallowing difficulty due to squamous cell cancer of the throat, and requires tube feedings. The interventions directed staff to check for tube placement prior to feeding and medication administration. R72's diagnoses listed on the December 2015 Physician Orders included dysphagia, malignant neoplasm of the mouth, GERD, and stroke. In addition, the orders directed staff to check for G-tube placement prior to feeding and medication administration. On 12/17/15, at 9:27 a.m. RN-D verified the gastrostomy tube placement should have been checked before giving the medications or tube feeding. RN-D stated they had never given gastrostomy tube medications or feedings via gravity through a syringe, "that is old practice." During interview on 12/17/15, at 2:07 p.m. the IDON stated, "I would expect the nurses to prepare the medications, go into the room and explain what they are doing to the resident, Check placement and check residuals, if ok, separate the plunger from the syringe, flush the tube and then pour each individual medication into the syringe flushing between meds. When done flush the tube, remove gloves and wash hands. You can mix all the meds if you have a doctor's order." R72's plan of care was not	F 282		

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F 282	Continued From page 15 followed for the checking of the placement of the g-tube. Skin alteration: R61's skin alteration was not monitored according to the plan of care. R61 was interviewed on 12/14/15, at 1:52 p.m. and during the interview R61 pulled up her left sweater sleeve and two old bruises were observed. When asked if someone had abused her R61 denied but added the staff rushed through cares/assisting her. On 12/16/15, at 7:10 a.m. R61 was observed all dressed had a sweater on seated on the w/c wheeling herself into the day room. When asked how she had slept R61 stated good but her arm was hurting at the time and thought was from arthritis. - At 7:30 a.m. to 7:40 a.m. R61 was observed asleep on her w/c on the far corner of the table and R61 had removed her sweater. There were bruises noted on the left arm fading and another fading bruise noted on the right arm. - At 7:45 a.m. restorative assistant (RA) approached R61 offered to join the exercise and wheeled her into the group. - At 7:59 a.m. RA approached asked R61 "You look tired do you want to stay for breakfast or go take a nap?" The resident stated "What time is it? It's hot in here." The RA then wheeled R61 to the table offered to remove her sweater completely but resident stated "just leave it." Bruises were visible. -At 8:08 a.m. resident at the table eyes closed. -At 8:15 a.m. to 8:50 a.m. observed resident	F 282		

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F 282	Continued From page 16 eating breakfast. R61's skin integrity assessment: preventation and treatment care plan dated 8/14/14, indicated resident was at risk related to impaired/decreased mobility, was incontinent of bowel and bladder and was at risk for bruising due to the use of Aspirin (used to treat mild to moderate pain and to reduce fever or inflammation). The care plan directed staff to inspect the skin for signs and symptoms of breakdown. An Occurrence Report dated 12/16/15, (after concern had been brought to the attention of facility staff by the surveyor), indicated R61 had several bruises/skin conditions to both arms. The note indicated the measurements of the bruises/skin conditions were as follows: - Right posterior forearm 2 centimeters (cm) x 1.5 cm resembled a bruise; - Right posterior lateral forearm 0.6 cm x 0.8 cm brown scaly lesion; - Right posterior distal upper arm 1.4 cm x 1.4 cm purple in color and scaly; - Right forearm proximal posterior lateral 0.6 cm x 0.6 cm purple and irregular shape; - Left lateral distal forearm 0.8 cm x 0.6 cm pink area; - Left posterior mid forearm 0.6 cm x 0.1 cm scabbed lesion; - Left lateral upper arm 0.6 cm x 0.4 cm irregular purple discoloration; - Left posterior proximal forearm 0.8 cm x 0.4 cm lesion. On 12/16/15, at 2:33 p.m. RN-B stated he would expect the staff to report any changes in skin	F 282		

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F 282	Continued From page 17 condition to the nurse if identified with cares when asked if it included any bruising. At 2:35 p.m. surveyor and RN-B went to room approached R61 who was seated on her wheelchair in her room. When RN-B started to look at R61's arms R61 stated "the kids make me get them because they grab me." RN-B verified the bruises on both arms stated the bruises were old bruises and was not able to describe some of the changes. On 12/17/15, at 7:56 a.m. the IDON stated an investigation had been started yesterday 12/16/15, after the concern had been brought to the facility attention and she thought resident was prone to bruising related to prophylactic Aspirin use, the way resident would position herself when in the common area and wheeling self around. When asked even though staff had identified possible causes if still any bruising was supposed to be investigated she indicated "Yes." The Pressure Ulcer CAA lacked R61's risk for bruising due to wheeling self around and positioning self as indicated by the IDON. On 12/17/15, at 3:00 p.m. IDON stated she would expect the NAs to report any change in skin to the nurse as soon as they are done with cares and the nurse needs to follow the facility protocol. The care plan for R61 was not followed for the observation of the changes in skin integrity. Wound Preventation and Management Clinical Program Manual effective July 2015, directed "Monitor area(s) of skin impairments e.g. abrasion, bruise, burn, excoriation, or rash daily using the Treatment Administration Record until healed..."	F 282		

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess for root cause and provide preventative measures to prevent bruising for 1 of 3 residents (R61) reviewed for non-pressure related skin issues. Findings include: On 12/14/15, at 1:52 p.m. during the interview R61 pulled up her left sweater sleeve and two old bruises were observed. On 12/16/15, at 7:10 a.m. R61 was observed all dressed had a sweater on seated on the wheelchair (w/c) wheeling herself into the day room. When asked how she had slept R61 stated good but her arm was hurting at the time and thought was from arthritis. - At 7:30 a.m. to 7:40 a.m. R61 was observed asleep on her w/c on the far corner of the table and R61 had removed her sweater. There were bruises noted on the left arm fading and another fading bruise noted on the right arm. - At 7:45 a.m. restorative assistant (RA) approached R61 offered to join the exercise and	F 309	F 309 An assessment was completed and monitoring was put into place on 12/16/2015 for R61 related to identifed non-pressure skin issues. All residents have the potential to be affected by the same practice. Education will be provided to staff as it relates to monitoring and reporting observations related to skin alteration(s) to the team member qualified to provide the necessary services by 1/26/2016. Audits will be completed by the DON and/or designee weekly for residents identifed to have non-pressure skin issues to ensure monitoring is in place. Audits will be reviewed during the quality assurance (QA)meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	1/26/16

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F 309	Continued From page 19	F 309		

wheeled her into the group.
- At 7:59 a.m. RA approached asked R61 "You look tired do you want to stay for breakfast or go take a nap?" The resident stated "What time is it? It's hot in here." The RA then wheeled R61 to the table offered to remove her sweater completely but resident stated "just leave it." Bruises were visible.
-At 8:08 a.m. resident at the table eyes closed.
-At 8:15 a.m. to 8:50 a.m. observed resident eating breakfast.

On 12/16/15, at 8:51 a.m. observed nursing assistant (NA) wheel resident out of the dining room her room then NA-C stated "I will see you later" resident stated "thank you" as resident wheeled self into her room."
- At 8:55 a.m. observed resident open the door t bathroom, then came out.
- At 8:56 a.m. overheard resident ca out "plea help" NA-C was observed go to r m assisted resident into the toilet. NA-C ass ed R61 to use the toilet and after applied a transfe elt arc nd the waist and transferred R61 t wheel h sweater still off never a ed R6 about the bruising wheeled resider th ugh the door out of the toilet to the sink area lo ted in the room and set resident to wash hands to Bruises were visible.

R61's skin integrity assessment: preventation and treatment care plan dated 8/14/14, indicated resident was at risk related to impaired/decreased mobility, was incontinent of bowel and bladder and was at risk for bruising due to the use of Aspirin (used to treat mild to moderate pain and to reduce fever or inflammation). The care plan directed staff to

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F 309	Continued From page 20 inspect the skin for signs and symptoms of breakdown. R61's Pressure ulcer Care Area Assessment dated 3/19/15, indicated R61 was at risk for pressure related issues due to being dependent in mobility and activities of daily living. R61's diagnoses included dementia non-Alzheimer's disease, seizure disorder/epilepsy, anxiety, osteoarthritis, osteoporosis, depressive disorder obtained from the quarterly Minimum Data Set (MDS) dated 11/25/15. In addition, the MDS indicated R61 had severely impaired cognition. An Occurrence Report dated 12/16/15, (after concern had been brought to the attention of facility staff by the surveyor), indicated R61 had several bruises/skin conditions to both arms. The note indicated the measurements of the bruises/skin conditions were as follows: - Right posterior forearm 2 centimeters (cm) x 1.6 cm resembled a bruise; - Right posterior lateral forearm 0.6 cm x 0.8 cm brown scaly lesion; - Right posterior distal upper arm 1.4 cm x 1.4 cm purple in color and scaly; - Right forearm proximal posterior lateral 0.6 cm x 0.6 cm purple and irregular shape; - Left lateral distal forearm 0.8 cm x 0.6 cm pink area; - Left posterior mid forearm 0.6 cm x 0.1 cm scabbed lesion; - Left lateral upper arm 0.6 cm x 0.4 cm irregular purple discoloration; - Left posterior proximal forearm 0.8 cm x 0.4 cm lesion.	F 309		

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F 309	Continued From page 21 On 12/16/15, at 2:30 p.m. NA-C was unavailable for interview to determine if the bruises were noted during morning cares. On 12/16/15, at 2:33 p.m. registered nurse (RN)-B stated he would expect the staff to report any changes in skin condition to the nurse if identified with cares when asked if it included any bruising. At 2:35 p.m. surveyor and RN-B went to room approached R61 who was seated on her wheelchair in her room. When RN-B started to look at R61's arms R61 stated "the kids make me get them because they grab me." RN-B verified the bruises on both arms stated the bruises were old bruises and was not able to describe some of the changes. On 12/17/15, at 7:56 a.m. the Interim director of nursing (IDON) stated she thought resident was prone to bruising related to prophylactic Aspirin use, the way resident would position herself when in the common area and wheeling self around. IDON indicated the Pressure Ulcer CAA lacked R61's risk for bruising due to wheeling self around and positioning self as indicated by the IDON. On 12/17/15, at 3:00 p.m. IDON stated she would expect the NAs to report any change in skin to the nurse as soon as they are done with cares and the nurse needs to follow the facility protocol. Wound Preventation and Management Clinical Program Manual effective July 2015, directed "Monitor area(s) of skin impairments e.g. abrasion, bruise, burn, excoriation, or rash daily using the Treatment Administration Record until	F 309		

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F 309	Continued From page 22 healed..."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure removal of facial hair was provided for 1 of 3 residents (R91) reviewed for activities of daily living and who was dependent on staff for shaving. Findings include: R91 was observed to be sitting in the wheelchair in his room on 12/14/15, at 3:53 p.m. and the resident face was covered with facial hair. When R91 was asked about if he shaved, he stated "I shave every morning" and "it disturbed him to be seen by a young lady unshaven." On 12/16/15, at 8:49 a.m. R91 was in the dining room eating breakfast and still was observed to be unshaven. On 12/17/15, at 7:45 a.m. and 1:07 p.m. R91 was seated in the area lounge and remained unshaven. The Nursing Notes were reviewed from 10/23/15 going forward, and the Nursing Notes were void of any refusals of care. R91's care plan dated 10/25/15, indicated R14	F 312	312 R91 was given extensive assist with his shaving needs on 12/18/2015. A facility wide audit was completed on 12/18/2015 and 17 male residents are noted to require extensive assist with shaving needs. In-servicing will be provided to all staff by 1/26/2016 that addresses need to provided to all staff by 1/26/2016. that addresses need to provide services by qualified persons in accordance with each residetn's POC. Staff in-servicing will also address direct observation and actions to be taken if residents are observed to be unshaven. Audits will be completed by the DON and/or designee that will monitor identified residents requiring asssit with shaving three times a week for two weeks, then weekly. The weekly audits will be completed during facility Caring Partners rounds. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are	1/26/16

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F 312	Continued From page 23 required extensive assist with personal hyigene which included combing of hair, shaving, dressing and undressing. The Minimum Data Set (MDS) dated 10/30/15, indicated R91 received extensive two person assist for personal hygiene. The MDS also noted R91 had no behaviors of refusal of care and the cognition level was severely impaired. On 12/17/15, at 10:52 a.m. nursing assistant-D stated, "told the manager 'yes [R91 needed to be shaved]' and the manager was going to go back and do it." On 12/17/15, at 12:43 p.m. registered nurse-B was interviewed and indicated R91 did not look like he got shaved. R91 did not receive the care and services for personal hygiene as he remained unshaved from 12/14 15 through 12/17/15. During interview on 12/17/15 at 2:0 p.m. the interiem director of nursing stated, "If a resident is asked about being shaved and says yes or requests to be shaved, I expect the staff to attempt to do it the same day unless the resident changes their mind. I would expect them to document if the resident refused when asked."	F 312	identified, and recommendations made for continued audits/monitoring needs.	
F 314 SS=D	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	F 314		1/26/16

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F 314	Continued From page 24 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, facility failed to ensure 1of 3 (R14) residents who had been identified at risk for pressure ulcers receive assistance with repositioning. Findings include: R14's Minimum Data Set (MDS) dated 12/8/15 indicated R14 was at high risk for pressure ulcers due to impaired bed mobility and impaired transfer. The MDS further noted R14 had an unstageable Stage 4 pressure ulcer (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) R14 required two person assist for transfers and bed mobility and had no behaviors of refusing care. According to the wound sheets the following was noted: - On 11/25/15, unstageable ulcer (full-tissue thickness loss in which the base of the ulcer was covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) measured 2.8 centimeters (cm) X 1.4 cm X 0.4 cm and healing well with no slough noted. - On 12/2/15, unstageable ulcer measured 2.8	F 314	F314 R14 elected Hospice services and the POC and physician orders were reviewed and updated. A facility wide audit was completed on 12/18/2015 with six residents identified that require assist with repositioning based on physician recommendations who also have pressure ulcers. In-servicing will be provided to nursing staff by 1/26/2016 that addresses a review of the skin integrity assessment prevention program and treatment POC for residents identified with repositioning and pressure ulcer treatment needs. Audits will be completed by the DON and/or designee that will monitor identified residents requiring assist with repositioning and pressure ulcer treatments three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommmendations made for continued audits/monitoring needs.	

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F 314	Continued From page 25 cm X 1.4 cm X 0.4 cm and no change from last week. - On 12/9/15, unstageable ulcer measured 2.4 cm X 0.6 cm X 0.4 cm and healing well with no slough noted. - On 12/15/15, unstageable ulcer measured 2.4 cm x 0.6 cm x 0.4cm and granulation noted with no drainage. Pink in color. R14's Skin Integrity Assessment:Prevention and Treatment Care Plan undated, instruct staff to implement an individualized turning schedule in applicable "q [every] 2 hrs [hours]", to lay R14 on the left side while in bed but not at all times, and to turn R14 with two pillows slightly high on side. Wheelchair (w/c) positioning per medical doctor (MD) order. Physician's Order signed 11/30/15, indicated staff were to "Reposition every 2 hours in bed and every 1 hour in chair." On 12/16/15, R14 was observed for repositioning and the following was noted: - At 9:45 a.m.R14 was up in the w/c with speech therapy in dining room (DR). - At 10:30 a.m. the resident was her room seated in the w/c. - At 10:45 a.m. the resident in lounge playing dice. - At 12:17 p.m. R14 was asleep in w/c in DR. - At 12:25 p.m. R14 was awake sitting at the table in the DR. - At 1:32 p.m. R14 was placed in her bed. R14 went for three and 45 minutes without being repositioned. On 12/16/15, at 12:25 p.m. R14 was interviewed	F 314		

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F 314	Continued From page 26	F 314		

and was asked if she had laid down. R14 replied, "I have not been to bed. I did not refuse. I would have preferred to sleep in my bed. I did enjoy the dice game. They said I need to eat."
- At 12:30 p.m. nursing assistant (NA)-B was interviewed and stated, "I have not laid her [R14] down yet.
- At 12:31 p.m. a second NA was interviewed and NA-D, remarked, "No, I have not laid her down she was playing dice and it is lunch now."
- At 1:32 p.m. registered nurse (RN)-B stated, "[R14] did not go to bed between breakfast and just now. We ideally only keep her up a couple of hours at a time. I have not seen her refuse to lay down."

On 12/17/15, at 10:38 a.m. NA-C stated R14 would ask for assistance when she needs to use the bathroom facilities. R14 was to be repositioned every two hours from left to right and she did not refuse to bed.
- At 10:52 a.m. NA-D stated R14 was to be repositioned every two hours and sometimes when R14 was in the chair the side(s) would lay her down after meals.
- At 12:33 p.m. RN-B stated the wound doctor here and the doctor noted the wound was better. RN-B remarked, "Staff normally turn and reposition her every two hours. She is compliant with turning and reposition. No one came and told me we were having problems." RN-B indicated the wound had been present for over three months and the facility measured the wound weekly.

During interview on 12/17/15, at 2:07 p.m. the interiem director of nursing stated, "If a resident is asked about being shaved and says yes or

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F 314	Continued From page 27 requests to be shaved, I expect the staff to attempt to do it the same day unless the resident changes their mind. I would expect them to document if the resident refused when asked."	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube (G-tube) prior to infusing medication and formula for 1 of 1 resident (R72) observed to have a tube feeding during the survey.	F 322	F 322 R72's Order and POC was reviewed on 12/17/2015 as it relates to G-tube placement, medication administration and nutritional formula tube feeding administration. Resident recieves bolus feedings, which is tolerated without sign	1/26/16

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F 322	Continued From page 28 Findings include: During medication administration observation and enteral feeding via R72's G-tube from 8:34 a.m. until 9:27 a.m. registered nurse (RN)-D was observed to flush the G-tube with 100 cubic centimeters (cc) of water without first checking placement. RN-D then continued to administer medications via drawing them up into a syringe and pushing them into the G-tube. After administering medications RN-D flushed the G-tube with 50 cc of water and drew up 50 cc of Jevity (a calorically dense nutritional formula for tube feeding) 1.5 with a syringe and pushed it into the G-tube. RN-D repeated that action until 225 cc of Jevity had been given. RN-D flushed the G-tube with 50 cc of water than gave the medication omeprazole (for gastroesophageal reflux disease-GERD) and flushed the g-tube with 50 cc of water. The Nutrition Risk Care Plan dated 10/[illegible]/14, listed as nutritional risk factors: cardiac disease, risk of dehydration, low sodium levels, (R72) typically consumed approximately 10 percent (%) of meals, swallowing difficulty due to squamous cell cancer of the throat, and requires tube feedings. The interventions directed staff to check for tube placement prior to feeding and medication administration. Nutritional Status care area assessment dated 8/18/15, indicated R72 received the majority of nutrition via feeding tube and was at risk for unsafe weight changes, dehydration and aspiration or choking. R72's quarterly Minimum Data Set dated	F 322	or sympotms of adverse affects, to allow increased independence rather than have a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolus tube feedings, g-tube placement verification and G-tube medication administration on 12/28/2015. A facility wide audit was completed on 12/17/2015 and four residetns were identified that have the potential to be affected by this practice. In servicing will be provided to nursing staff by 1/26/2016 that addresses standards of practice as it relates to G-tubes utilizing facility policies and procedures as well as the CMS tube feeding status critical element pathway tool. Audits will be completed by the DON and/or designee that will monitor identified residents requireing G-tube placement checks, medicaiton and tube feeding administrations, three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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F 322	Continued From page 29 11/12/15, indicated R72 was cognitively intact and received "51 % or more" of his total calories through the feeding tube." R72's diagnoses listed on the December 2015 Physician Orders included dysphagia, malignant neoplasm of the mouth, GERD, chronic obstructive pulmonary disease, and stroke. In addition, the orders directed staff to check for G-tube placement prior to feeding and medication administration. On 12/17/15, at 9:27 a.m. RN-D verified the gastrostomy tube placement should have been checked before giving the medication or tube feeding. RN-D stated they had never given gastrostomy tube medications or feedings via gravity through a syringe, "that is old practice." During interview on 12/17/15, at 9:3[illegible]a.m. RN-A stated the nurse should have checked placement and residuals before giving anything by a G-tube. RN-A verified when a nurse administered medication by a G-tube they would flush the G-tube with water then add water to the crushed medications, take the syringe apart, pour the medication in the syringe. "You might have to keep adding water to the cup to make sure you get it all the medication. You would then do liquid medications, rinse out cup. Then you would flush the feeding tube." During interview on 12/17/15, at 2:07 p.m. the interim director of nursing stated, "I would expect the nurses to prepare the medications, go into the room and explain what they are doing to the resident, Check placement and check residuals, if ok, separate the plunger from the syringe, flush	F 322		

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F 322	Continued From page 30 the tube and then pour each individual medication into the syringe flushing between meds. When done flush the tube, remove gloves and wash hands. You can mix all the meds if you have a doctor's order." Enteral Tubes procedure dated July 2015 instructed staff to: "10. Verify tube placement. a. install 10-20 mL [milliliters] of air into the tube while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope to validate air movement in the stomach and b. Aspirate 2-10 mL of gastric contents and reinstall." "13. Remove plunger from syringe, attach syringe to tube pour medication(s) into syringe, and allow to flow by gravity."	F 322		
F 323 SS=E	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 review, the facility failed to ensure supervision for smoking materials was provided for 9 of 16 residents (R167, R43, R31, R41, R72, R68, R8, R168, R135). In addition, the facility failed to	F 323	F 323 Smoking: On 12/22/2015 the smoking safety data collection and assessment was completed for R167 and resident's status	1/26/16

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F 323	Continued From page 31 ensure a stand lift was properly used for 1 of 1 residents (R13) who was observed for transfers. Findings include: During the evening of 12/14, and the days of 12/15, 12/16, and 12/17/15, of the survey, observations were made of the smoking structure (three sided tent) in the parking lot on the Grimes Ave entrance. There were burn marks in three of three wooden benches in the smoking area, and cigarette butts strewn on the ground from the front door to the smoking structure. Cigarette butts were observed in the garbage can, next to the smoking receptacle. The facility smoking policy directed smokers assessed as independent would keep their smoking materials in a locked drawer in their room. Smokers assessed as dependent would have smoking materials secured in the medication rooms. R167 was identified by the facility as a smoker, and was admitted to the facility on 12/10/15 with diagnosis of right lung cancer with metastatic (spread) to brain with mass affect (the cancer tumor is pressing the brain to the side, causing increased pressure in the brain). The care plan dated 12/10/15, indicated family would provide smoking materials and assist with smoking secondary to weakness. The Smoking Safety Data Collection and Assessment dated 12/14/15, indicated R167 could not light his cigarette independently if it was windy, due to use of only one hand. R167 was not able to let go of cigarette and then retrieve it due to weakness. R167 was assessed	F 323	has improved and R167 is now assessed as an independent smoker. R167's family and the POC were updated. On 12/22/2015 the smoking policy and procedure was reviewed with R167. On 12/[illegible]9/2015 the smoking policy and procedure was reviewed with R43 and guardian and the POC was updated. On 12/24/2015 the smoking policy and procedure was reviewed with R31, R41, R[illegible]2, and R68. On 12/24/2015 the smoking policy and procedure was reviewed with R118. Note the resident is identified as R8 on the statement of deficiencies, but upon review this is a typo and should read "R118" as there is no R8 on the listing provided by the survey team member. R168 was discharged; however, a smoking safety data collection and assessment was completed as well as a review of the smoking policy and procedure prior to discharge. R135 was discharged. A facility wide audit was completed on 12/17/2015 and fifteen residents have the potential to be affected by this practice. Lock boxes and/or bedside tables with locking drawers were provided for all identified resdients on 12/31/2015. All staff will be in-serviced by 1/26/2016 on smoking policy and procedure as well as interventions in place for identified residents. Audits will be completed by the Director of	

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F 323	Continued From page 32 as a dependent smoking and would smoke with family, who visited daily. On 12/15/15, at 1:55 p.m. R167 stated he kept his cigarettes and lighter in his coat pocket for easy retrieval. R167 stated he only smoked with his family outside, he just liked to keep the cigarettes and lighter in his pocket, even though he knew they should be kept at the nursing station. On 12/15/15, the fire marshal surveyed the facility and also identified the issues with the smoking area, and directed the facility to reassess all residents for safe smoking. On 12/16/15, at 9:55 a.m. licensed practical nurse (LPN)-C stated R167's cigarettes were secured in the 4th floor medication room. The cigarettes were observed in the medication room. On 12/16/15, at 10:00 a.m. R167 stated the social worker came and took his cigarettes last night. With permission the jacket pocket was checked, the cigarettes and lighter were no longer in the pocket. R43's quarterly Minimum Data Set (MDS) dated 9/11/15, indicated R43 had severely impaired cognition. Elopement plan of care dated 9/11/15, indicated resident had dementia and was on a smoking program and always returned to the floor/unit/room after going out to smoke. R43's diagnoses included dementia, major depressive disorder, alcohol use and encephalopathy obtained from the admission record dated 10/13/15.	F 323	Social Services and/or designee that will monitor random identified residents five times a week for one week, then three times a week for one week, and weekly thereafter. Audits will aslo include that cigarettes are being properly disposed of. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs. Safe transfers: On 12/28/2015 Director of Rehabilitation (DOR) completed a clincial review to assist in modifications to R13's POC as it relates to transfers and toilet use. R13's POC was updated. A facility wide audit was completed on 12/17/2015 and twenty residents have the potential to be affected by this practice for which staff use the mechanical lift. In-servicing will be provided to nursing staff by 1/26/2016 that addresses standards of practice as it relates to safe transfer techniques. Audits will be completed by the DON and/or designee that will monitor identified residents requiring transfer assist, including those residents who require the use of a mechanical lift, three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance(QA) meeting to determine if any trends are identified, and recommendations made for continued	

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F 323	Continued From page 33 The Smoking Safety Data Collection and Assessment dated 12/09/15, indicated R43 an independent smoker, however the assessment did not indicated storage of the cigarettes, and lighters had been reviewed to ensure R43 understood where to store them per the facility policy. On 12/15/15, at 9:11 a.m. during a tour to the smoking area located to the left side of the entrance door surveyors observed a concert garbage with the inside made of hard plastic stationed outside the tent. The can was lined with a clear plastic bag and trash with multiple cigarette butts were observed disposed in the can. Right next to garbage can was a black cigarette receptacle that was observed to be filled and cigarette butts were seated on the receptacle hole. Also noticed were several cigarettes butts in the area on the floor all the way to the entrance past the yellow line and the benches located inside the smoking tent were observed with burn marks along the sitting part. At the time of observation two residents in the area smoking which included R43. At 9:14 a.m. R43 was observed dispose the cigarette butt in the receptacle by the garbage that was filled and left the area after putting the lighter in her jacket and went into the building. During observation R43's clothing checked no burns holes noted. On 12/16/15, at 3:45 p.m. observed several residents inside the tent smoking at the time. The smoke receptacle stationed by the garbage can observed to be full and some cigarette butts observed inside the garbage can at the time.	F 323	audits/monitoring needs.	

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F 323	Continued From page 34 On 12/17/15, at 10:37 a.m. during the environment tour under R43's wheelchair cushion was observed two cigarettes and a lighter stored when staff brought the wheelchair out of the room to be reviewed. During the tour the executive director and several other management staff were present. On 12/15/15, at 1:09 p.m. housekeeping aide (HKA)-A stated "I actually do not see that many the smokers go out as they go when they want and has not seen them stored" when asked what she could do if she saw the cigarettes stored all around the room. HKA further stated if she would find cigarettes for a resident who left them lying around the room she would bring them to the nurse to make sure the resident was supposed to have the cigarettes. -At 1:12 p.m. the floor care tech stated she saw some residents store cigarettes in their bedside tables and night stands, "I have seen a lighter out in the room and this person I believe he can have it and goes out to smoke. I know another resident in the third floor she is on a program and I could ask." When asked if she would take the cigarettes and lighter to the nurse if she saw them not stored properly floor care tech stated "On the residents who I know go out to smoke I would not take it out of the room. Some residents have their families bring smokes. Some residents would be begging for smokes and we have been told not to give them." When HKA-A and floor care tech were both asked if they knew the facility smoking policy both stated for those residents who are okay to go out smoke were able to keep all their supply in their possession and for those who were in the program would have their cigarettes stored in the medication	F 323		

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F 323	Continued From page 35 room. When asked if either of them knew the facility smoking policy both stated they were not sure at this time and would get back to surveyor. When asked specifically about smoking supplies being locked both stated they were neither sure and would be getting back to surveyor about it. Both indicated residents were not supposed to smoke with oxygen and would have the tank at the front of the building and would not get it after they are done smoking. On 12/15/15, at 1:31 p.m. the executive director (ED) stated she had not seen any resident out smoke with oxygen. ED stated she had worked at the facility for five years and had not had anyone out smoking with oxygen. When asked about the smoking policy ED stated was done on general orientation. ED stated "We have not had anyone flag as not being safe. Social service completes the assessment and some of the unit managers would help and in the past some residents have had to swap cigarettes with their oxygen tank. In the past they have left the tank at the front and had been very reliable." When asked if she would expect all the staff to know the smoking policy ED stated she would not expect as this was more clinical and thought the staff should be able to notice the safety but would not be able to know the answers exactly to the policy. When asked about storage of cigarettes and other supplies ED stated if residents had on their possession would be safe like in their pockets as they had been assessed to be safe to smoke and handle the supplies. ED also stated if a resident would take cigarettes and other supplies and left them on the bed it would flag for the resident to be re-assessed. When asked about checks/audits were done to make sure residents followed	F 323		

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through with the policy ED stated she did do audits and would check and if she had noticed any concerns would address it immediately. ED further stated she had not seen any concerns during her audits and thought the facility had one of the best smoking programs.

On 12/16/15, at 7:39 a.m. both the floor care tech and HKA-A approached and stated residents would be able to keep the cigarettes on them and also have them stored in the cabinets in their rooms which they had a key to.

R31's Mood and behavior symptom assessment/plan of care rewritten 5/8/15, indicated resident smoking in-between door on first floor. Interventions included offer to get jacket and remind of risks and consequences of not wearing a jacket. Re-direct and remind of rules and consequences.

The Care Area Assessment (CAA) dated 5/18/15, indicated cognitive impairment. CAA dated 5/15/15, indicated poor memory.

The Fall injury assessment, prevention and management plan of care dated 5/15, plan entry dated 12/15/15, indicated resident found to have lighter fluid in his room, goal was to comply with smoking policy and intervention was to remind him of the smoking policy. Maintenance will hold onto can for resident and when he wants to refill request assist.

R31's smoking safety data collection and assessments dated 11/6/15, indicated R31 was an independent smoker. Non-compliance with smoking policy was checked along with address

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goals and interventions on the plan of care. Smoking assessment dated 8/27/15, 5/8/15, and 2/6/15, indicated resident was an independent smoker and the assessment would be addressed on the plan of care were checked.

The quarterly MDS dated 11/6/15, indicated moderate cognitive impairment and diagnoses included hypertension and peripheral vascular disease.

The comprehensive care plan review summary dated 11/18/15, indicated R31 was a smoker, smoking safety dated collection and assessment reviewed and updated and care plan reviewed and updated.

On 12/15/15, at 11:49 a.m. R31 not in room, no cigarettes observed in room. At 11:57 a.m. observed R31 in his wheelchair going down the hall toward his room. R31 stated he did smoke and had a pack of cigarettes in his wheelchair. R31 indicated he rolled his own cigarettes and had done that for two years now. He stated shoppers get materials for him and that he received some today. In the room next to his, which was used as a library observed on the table was a rolling machine, tobacco, approximately four lighters in a drawer, and a BiC lighter that he kept with him. He also had a Zippo lighter fluid bottle on the shelf above the table, which stated flammable on the outside. R31 stated the Zippo should be tossed. R31 also had 10 rolled cigarettes in a box on the table. R31 stated other residents do not wander in the room, they ask permission to come into his library.

On 12/15/15, at 12:09 p.m. registered nurse

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(RN)-A stated he was not aware of the Zippo lighter fluid. R31 stated it should be tossed and RN-A stated it would be tossed. At 12:17 p.m. RN-A stated it was disposed of properly. At 12:57 p.m. RN-A stated he gave it to the maintenance director, indicated they had a locked place in their shop to lock flammables.

R41's Fall/injury assessment: prevention and management plan of care dated 5/14 indicated R41 rolled her own cigarettes occasionally.

R41's smoking safety data collection and assessments dated 1/6/15, 4/17/15, and 10/5/15 indicated R41 was an independent smoker and address goals and interventions on the plan of care were checked. On the 7/10/15, assessment it was written in "reviewed 10/6/15-no changes-signed by [RN-A]."

The quarterly MDS dated 10/5/15 indicated R41 was cognitively intact and diagnoses included anemia and hypertension.

The Comprehensive care plan review summary dated 10/9/15, indicated R41 was smoker, smoking safety data collection and assessment reviewed and updated and care plan reviewed and updated.

On 12/15/15, at 11:51 a.m. R41 was lying in bed in her room and stated she was not feeling well today. R41 opened her bedside dresser's second drawer and showed me a pack of 18 cigarettes. R41 had two packs of cigarettes in the top locked drawer and half (½) carton in the bottom drawer. R41 stated she kept a lighter in her jacket and

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F 323	Continued From page 39 smoked outside. R72's mood and behavior symptom assessment care plan dated rewritten 10/3/14, entry dated 8/14, indicated R72 started to roll his own cigarettes. R72's smoking safety data collection and assessments dated 2/14/15, 5/15/15, 8/12/15, and 11/12/15 indicated resident was an independent smoker and address goals and interventions on the plan of care were checked. R72's Fall/injury assessment: prevention and management plan of care dated 8/12/15, indicated R72 was independent with smoking. The CAA dated 8/18/15, indicated R72 had cognitive impairment. The quarterly MDS dated 11/12/15, indicated R72 was cognitively intact and diagnoses included anemia, hypertension, cerebrovascular accident and dementia. The comprehensive care plan review summary dated 11/25/15, indicated R72 was a smoker. On 12/15/15, at 11:44 a.m. observed resident's room to have six empty cigarette packages on top of the refrigerator and three empty packages on top of the dresser table eight individual cigarettes were observed on the bedside table, 10 cigarettes were in a pack in his hat, along with a lighter on the bedside table. R72 stated he was able to smoke outside anytime and stated he had	F 323		

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F 323	Continued From page 40 no cigarettes in his bedside drawer. R68 On 12/15/15, at 12:19 p.m. R68 stated she rarely smoked and kept a partial cigarette pack and lighter in her camp hero jacket. R68 stated she smoked about two to three cigarettes a day. R68's 11/25/15, smoking safety data collection and assessment indicated independent smoker "resident signs in & out at desk" and address goals and interventions on the plan of care was checked. The quarterly MDS dated 11/25/15, indicated R68 was cognitively intact and diagnoses included cerebrovascular accident. R8 On 12/15/15, at 11:56 a.m. R8 was not in his room but was observed a pack of 10 cigarettes and lighter sitting on top of a boom box resting on sink counter. R8 was in the dining room and stated that he kept cigarettes in a drawer in his room. R8's smoking safety data collection and assessment dated 11/11/15, indicated R8 was an independent smoker. The quarterly MDS dated indicated 11/11/15, indicated R8 had moderate cognitive impairment and diagnoses included hypertension and dementia.	F 323		

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F 323	Continued From page 41 R168 On 12/15/15, at 12:25 p.m. R168 was in the dining room, stated he had a half pack of cigarettes and lighter in his jacket but did not have any extra cigarettes. R168's smoking safety data collection and assessment dated 12/10/15, indicated R168 was an independent smoker and address goals and interventions on the plan of care was checked. The Fall/injury assessment: prevention and management care plan dated 12/9/15, indicated fall/injury risk related to smoking. The undated comprehensive care plan review summary for R168 indicated smoker. On 12/15/15, at 12:59 p.m. nursing assistant (NA)-A stated if she saw smoking materials she would report it to the nurse and charge nurse. There was no smoking allowed in the building, residents have to smoke in the area outside. On 12/15/15, at 1:01 p.m. LPN-A stated sometimes she saw materials in certain rooms, usually a lighter, roll paper and bags of tobacco. If they were not harming anything she would let it be. If the resident was at risk she would involve social services. Social services divided cigarettes and handed them out in the morning. Social services supplies cigarettes to residents and they are purchased with resident's money. A resident must go outside past the door, past the line to the smoke shack. Some people have had certain smoking times in the past, they would keep a lighter at the desk, would go downstairs with a resident, light their cigarettes, watched them	F 323		

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F 323	Continued From page 42 smoke and brought them back upstairs. On 12/15/15, at 1:11 p.m. NA-B stated if she saw smoking materials in rooms she would take it to the nurse's station. NA-B stated she was not aware of the smoking policy. On 12/15/15, at 1:14 p.m. RN-A stated he did not know what he would do if he saw smoking materials out and about. It is their home if they want to leave smoking materials on their table. They do not have problems with other people going into rooms and stated he did not have concerns with cigarette stealers. If they did have a concern he would suggest the cigarettes were locked up. RN-A stated he had not read the smoking policy thoroughly. If a resident was a dependent smoker, the cigarettes and lighter were locked up, meaning they could not smoke on their own. They did have one resident who they locked and distribute her cigarettes. She had six cigarettes kept on the medication cart to avoid all her money being spent on cigarettes. RN-A stated everyone else was an independent smoker. He indicated he would refer to the smoking policy to read it. RN-A stated he was not aware of who was in charge of the policy or how they were ensuring it. R135 was admitted to the facility on 7/23/15, and was identified by the facility as a smoker on the Nursing Comprehensive Admission Data Collection an Assessment dated 7/23/15. Nursing Comprehensive Admission Data Collection an Assessment indicated, "Complete Smoking Safety Data Collection and Assessment, if yes (or according to state-specific policy)."	F 323		

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F 323	Continued From page 43 R135's admission MDS dated 7/30/15, indicated R135 was cognitively intact and required assistance with activities of daily living (ADLs). R135's admission MDS indicated R135 had diagnoses of a stroke, hemiplegia (paralysis on non-dominate side), seizures, asthma, history of cocaine abuse, intracranial hemorrhage (bleeding in the brain), The Progress Note dated 7/30/15, indicated R135 was found smoking in his room. Progress Note dated 7/31/15, indicated a care conference was held and social service reviewed the smoking policy and procedure. R135 would go with family to smoke. The Smoking Safety Data Collection and Assessment dated 7/30/15, indicated R135 was assessed as an independent smoker. R135's Fall/Injury Assessment: Prevention and Management Care Plan undated page 4 indicated "Assessment Fall/Injury risk related to: Smoking I (independent) Goal will demonstrate safe smoking daily Intervention Monitor compliance to smoking policy." R135's Fall/Injury Assessment: Prevention and Management Care Plan undated page 4 indicated "Assessment Fall/Injury risk related to: Smoking I (independent) Goal Will demonstrate safe smoking daily Intervention Monitor compliance to smoking policy." R135's Social Service Short Stay Plan of Care page 2 dated 7/30/15, indicated "[R135] was smoking in his room. Intervention instructed staff, "Resident's cigarettes & [and] lighter to be kept at	F 323		

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F 323	Continued From page 44 nurses station. Staff will not take resident to smoke, but family members can do so." On 12/15/15, at 1:05 p.m. when asked are you aware of the smoking policy? LPN-D answered yes a resident can not smoke in their bathroom or room. On 12/15/15, at 1:10 p.m. when asked how the facility enforces the smoking policy? RN-B stated we ensure the residents remain safe. If not we have to intervene to allow them to smoke. We will have a family member go out and smoke with them if the resident needs to be supervised. During interview on 12/17/15, at 2:07 p.m. when the interim director of nurses (IDON) was asked about R135 smoking in room in July, IDON stated there would have been an incident report. Requested IDON locate it and provide to surveyor as it was not provided when requested earlier. Also requested copy of smoking assessment and progress notes for 7/23 through 7/301/15. The director of nursing (DON) stated social service does the smoking assessments. When should a resident who is identified to smoke upon admission have a smoking assessment completed DON stated, "talk to [social worker (SW)-A], she will know what the policy is." During interview on 12/17/15, at 3:45 p.m. SW-A said if residents want to smoke I do the assessment on the day of admission or the next day, otherwise I hold off until they want to smoke. They (resident) may say they smoke but have not smoked since they have been in the hospital. I talk to the resident upon admission about the	F 323		

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F 323	Continued From page 45 smoking protocol and let them know there are regulations. I was off on 7/23/15, and 7/24/15. If a transitional care unit resident admits the social worker will talk to the resident. Residents can not smoke in their room MN (Minnesota) Smoking policy revised January 2014, directed: "1. All residents who smoke will be evaluated upon admission, quarterly, and with a significant change of condition, to determine any special smoking needs and to assess their ability to smoke independently. 2. Results of the smoking evaluation will be discussed with the resident/responsible party and addressed in the resident's care Plan. 3. All residents who smoke may only smoke in a designated smoking area... 9. Residents who are assessed as "Independent smokers may retain possession of their smoking material per the care plan. In such circumstances a locked storage cabinet will be provided. Such residents must adhere to the following requirements: · Combustible items other than smoking materials will not be stored in the locked cabinet · Storage cabinet will be locked at all times with the key in the possession of the resident · No smoking materials will be stored for or given to another resident..." The facility did not follow the policy as the residents had kept either or both smoking materials on their possession. Safe transfers: R13 was observed on 12/16/15, at 7:38 a.m. for morning cares. The cares were completed NA-C.	F 323		

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F 323	Continued From page 46 R13 indicated she had to use the bathroom. R13 was assisted to the edge of the bed by two NA assist. When the NA-C went to put the safety belt around R13 the belt would not fit as it was too "tight." The belt was adjusted and again it would not fit. The Velcro safety straps were not used to transfer R13 to the toilet. NA-C assisted the stand into the correct position over the toilet and then R13 was lowered to sit on the toilet. After the toilet use R13 was placed in the wheelchair (w/c) by having staff tilt the w/c backwards to accommodate the legs of the stand as the stand legs could not spread as wide as the w/c width. R13 was admitted to the facility 5/31/14, with admission diagnoses of stroke with hemiplegia (loss of use of one side of the body) dysphagia (difficulty swallowing food and liquids) and apraxia of speech (difficulty with expressing thoughts). The annual CAA dated 3/6/15, indicated R13 was unable to participate in cares due to body habitus and refusals of care. R13 required assist of two staff and a stand assist lift to toilet, was usually incontinent and noncompliant with toileting schedule. The care plan dated 3/9/15, indicated assist of two staff with "EZ stand" [Stand Up Patient Lift] for bed/chair/toilet. The quarterly MDS dated 11/13/15, indicated R13 was cognitively intact, moderately depressed and required extensive assist of two staff with mechanical stand lift for transfer and toilet use. R13 also had no falls in the past tree months.	F 323		

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F 323	Continued From page 47 On 12/17/15, at 7:13 a.m. RN-B stated, the staff have to lift the w/c to get R13 far enough back, because the legs on the stand would not spread far enough to get over R13's w/c. RN-B "That's what we figured out to get her far enough back in the w/c." On 12/17/15, at 7:33, NA-C stated "it's been a while since they have been lifting the chair to get her back far enough in the chair that she was comfortable." On 12/17/15, at 2:05 p.m. RN-C was interviewed and indicated the staff did not follow proper policy and they should have gotten a physical therapy (PT) lift assessment. At 3:48 p.m. RN-C stated R13 "had not had a PT assessment since September 2014, so that assessment would not be accurate for the current time period." The manufacturers manual for the Stand Up Patient Lift dated 2010 directed staff "if any attachments are not properly in place, lower the patient back onto the stationary surface and correct this problem - otherwise injury or damage may occur." Staff were to also detect wear and damage to all parts e.g. "slings, lifting arm and any pivot for slings for signs of cracking, fraying, deformation or deterioration. Replace any defective parts IMMEDIATELY and ensure that the lift is not used until repairs are made."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or	F 329		1/26/16

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F 329	Continued From page 48 without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility did not ensure adverse side effect monitoring was being completed for 1 of 5 residents (R68) reviewed for unnecessary medications. Findings include: R68's Care Area Assessment dated 4/24/15, indicated R68 received antipsychotic medications. The facility's consultant pharmacy report entitled, Consultation Report Omnicare of Minnesota dated 5/12/15, included: "receives an	F 329	F 329 Medication monitoring including postural blood pressures, (e.g. orthostatic blood pressures) for R68 was put into place on 12/28/2015. All residents have the potential to be affected by this same practice; however, a facility wide audit was completed on 12/28/2015 and fourteen residents were identified at risk for monitoring needs for postural blood pressure needs. Nursing staff will be in-serviced by 1/26/2016 on policy and procedure for	

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F 329	Continued From page 49 antipsychotic, and is reported to have fallen or be at high risk for falls... Please consider monitoring postural blood pressures (BP) at least monthly/assessing for orthostatic hypotension per facility policy (or as advised by prescriber)." The medical record lacked any evidence of this irregularity having been brought forward to the facility's attention again even though no orthostatic blood pressures for R68 had been completed since May of 2015. The Medication Administration Record (MAR) included an order dated 5/13/15, for orthostatic blood pressures to be completed monthly, if utilizing an antipsychotic. R68's MAR for May 2015 indicated monitoring of orthostatic blood pressures had not been completed. In addition, the medical record, which included the MAR and Treatment Administration Record, lacked evidence of any orthostatic blood pressures having been monitored between May and November of 2015. The facility provided R68's current care plan dated 5/15/15. The care plan lacked any interventions for adverse side effect monitoring for R68's use of Seroquel (an antipsychotic) or Zoloft (an antidepressant). Although there was an opportunity to have selected interventions appropriate for such monitoring, an entire section of the plan remained unchecked including: Repetitive physical movement, balance while sitting, hypotension, dizziness/vertigo, syncope, unsteady gait, fall in past 30 days, fall in past 31-180 days, hip fracture, swallowing problem, weight loss and orthostatic BP. R68's quarterly Minimum Data Set (MDS) dated	F 329	psychoactive medication symptom assessment/care plan needs. Audits will be completed by the DON and/or designee for identified residents to ensure adequate monitoring is in place weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendation is made for continued audits/monitoring needs.	

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F 329	Continued From page 50 11/27/15, indicated R68 was cognitively intact and had diagnoses including: cerebrovascular accident, traumatic brain injury, anxiety, and depression. R68 was independent with most activities of daily living and required supervision, and set up help only with locomotion off unit. The MDS also indicated R68 had been admitted to the facility on 4/16/15. The signed Physician Orders for December 2015, indicated R68 received Seroquel 25 milligrams (mg) every morning, and 50 mg every evening for mood disorder. Staff were also to monitor for the risk of psychopharmacological medications and if noted staff were to document the information in the medical record and notify the medical doctor. The licensed nurses documented "O" for monitoring for the risk of psychopharmacological medications however, there were no documented orthostatic blood pressures as recommended by the pharmacist to help identify potential adverse side effects for the use of Seroquel. On 12/17/15 at 9:39 a.m., registered nurse (RN)-B stated they did not monitor orthostatic blood pressures. On 12/17/15 at 3:23 p.m., the interim director of nursing (IDON) stated she did not see documentation indicating orthostatic blood pressures were being monitored. The IDON confirmed she expected such monitoring to be implemented in accordance with the consultant pharmacist's recommendation. The package insert information for Seroquel from AstraZeneca Pharmaceuticals, last revised	F 329		

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F 329	Continued From page 51 10/29/13, indicated one of the adverse side effects for Seroquel was orthostatic hypotension. The information included; "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose." The facility's policy Psychoactive Medication dated 7/15, directed staff to "Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Care Plan." R68's care plan dated 5/15/15, was void any symptoms to monitor for side effects.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to prevent medication errors for 2 of 7 Residents (R72, R76) reviewed for medication administration. This resulted in a 7.7% medication error rate. Findings include: Gastrostomy tube (G-Tube) administration: R72's G-Tube medication administration and enteral feeding was observed from 8:34 a.m. until 9:27 a.m. registered nurse (RN)-D was observed	F 332	F 332 G-Tube placement: R72's Orders and POC was reviewed on 12/17/2015 as it relates to G-tube placement, medication administration and nutritional formula tube feeding administration. Resident receives bolus feedings, which is tolerated without sign or symptoms of adverse affects, to allow for increased independence rather than have a continuous tube feeding formula administered. RN-D was provided	1/26/16

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F 332	Continued From page 52 to crush the listed medications and place them in a blue plastic cup. The medications were Aspirin (a mild analgesic) 81 milligrams (mg) chewable one tablet, Baclofen (a muscle relaxer) 10 mg one tablet, Wellbutrin (an antidepressant) 75 mg two tablets, Finasteride (treatment of benign prostatic hyperplasia (BPH) 5 mg one tablet Norco (an analgesic) 5 mg-325 mg one tablet, Keppra (used to treat epilepsy) 750 mg one tablet, and Calcium with vitamin D 500 mg-200 units (promote bone growth). RN-D poured 20 milliliters (ml) of omeprazole (used to treat gastroesophageal reflux) into a medication cup as ordered by the December 2015 Physician Orders. RN-D put on gloves and using a 60 cc (cubic centimeter) syringe, drew up 50 cc of water and pushed it into the G-Tube, RN-D drew up another 50 cc of water and pushed it into the G-Tube. RN-D then added 50 cc of water and added it to the plastic cup containing the medications. Using the 60 cc syringe RN-D drew up the medication and pushed the meds into the G-Tube. RN-D then threw the plastic cup that had contained the medications in the trash with white liquid and lumps in bottom of cup. RN-D then flushed the G-tube with 50 cc of water and drew up 50 cc of Jevity (nutritional supplement) 1.5 with a syringe and pushed it into the G-Tube until 225 cc of Jevity had been given. RN-d flushed the G-tube with 50 cc of water than gave the omeprazole and flushed the G-tube with 50 cc of water. A visible layer of omeprazole remained in the medication cup.	F 332	re-education as it relates to bolus tube feedings, g-tube placement verification and G-tube medication administration on 12/28/2015. A facility wide audit was completed on 12/17/2015 and four residents were identified that have the potential to be affected by this practice. In-servicing will be provided to staff by 1/26/2016 that addresses standards of practice and it relates to G-tubes and tube feeding. Audits will be completed by the DON and/or designee that will monitor identified residents requiring G-tube placement checks, medication and tube feeding administrations, three times a week for two weeks, the weekly. Audits will be reviewed durign the qulaity assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs. Insulin administration On 12/28/2015 R76's blood sugars were reviewed and results were discussed with the diabetic clinic with no new orders noted. Resident is without any adverse effects noted related to this practice. A facility wide audit was completed on 12/28/2015 and sixteen residents have the potential to be affected. Nursing staff will be in-serviced by 1/26/2016 and will include policies and procedures related to insulin injection,	

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F 332	Continued From page 53 R72's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated R72 was cognitively intact and was independent with activities of daily living with the exception of eating. R72's diagnoses listed on the December 2015 Physician Orders included dysphagia, and malignant neoplasm of the mouth. In addition, the orders read, "Ok to crush and give meds together, flush with 60 ML [milliliters] of H2O (water) following meds," "Give all Meds via GT," and "Check for G-tube placement prior to feeding and medication administration. Flush G-tube with 250 ml of water at 12 midnight, 9 AM, 12 PM, 2 PM, 4 PM and 8 PM." At 12/17/15, at 9:27 am RN-D verified there was medication powder and fragments still left in the bottom of the cup that the dissolved pills were in. RN-D verified that the medication cup containing the crushed medications still had medication in it. RN-D also verified the medication cup containing omeprazole still had medication in it. RN-D acknowledged the gastrostomy tube placement should have been checked before giving the medication or tube feeding. RN-D stated had never given gastrostomy tube medications or feedings via gravity through a syringe, "that is old practice." During interview on 12/17/15, at 9:33 a.m. RN-A stated a nurse should check placement and residuals before giving anything by a gastrostomy tube. RN-A verified when a nurse administers medication by a G-tube they would flush the G-tube with water then add water to the crushed medications, take the syringe apart, pour the medication in the syringe. You might have to	F 332	utilization of FlexPens, glucose monitoring and infection control. Audits will be completed by the DON and/or designee that will monitor identified residents requiring insulin injections three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified and recommendations made for continued audits/monitoring needs.	

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F 332	Continued From page 54 keep adding water to the cup to make sure you get it all the medication. You would then do liquid medications, rinse out cup. Then you would flush the feeding tube. During interview on 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) stated, "I would expect the nurses to prepare the medications, go into the room and explain what they are doing to the resident, Check placement and check residuals, if ok, separate the plunger from the syringe, flush the tube and then pour each individual medication into the syringe flushing between meds. When done flush the tube, remove gloves and wash hands. You can mix all the meds if you have a doctor's order." Enteral Tubes procedure dated July 2015 instructed staff to: "10. Verify tube placement. a. install 10-20 ml of air into the tube while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope to validate air movement in the stomach and b. Aspirate 2-10 mL of gastric contents and reinstall." "13. Remove plunger from syringe, attach syringe to tube pour medication(s) into syringe, and allow to flow by gravity." R72 did not receive the full dose of medications as ordered by the physician. Insulin administration: R76s Admission Record dated December 2015, indicated R76 had diagnosis of diabetes mellitus. R76's blood sugars between 12/1/15, to 12/16/15, ranged from a low of 115 to a high of	F 332		

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F 332	Continued From page 55 316. The Physicians Order for the period December 2015, directed staff to administer Novolog Flexpen (used to control blood sugar) 100 unit/milliliter sliding scale based three times a day with meals For blood sugar 150-200=4 units, 201-250=8 units 251-300= 12 units 301-350=16 units, 351-400= 20 units, blood sugar greater than 400 =24 units. During medication administration observation on 12/16/15, at 12:18 p.m. licensed practical nurse (LPN)-B verbalized R76's blood sugar was 223 and would need eight units of Novolog. LPN-B attached the needle to the Flexpen and dialed 8 units for administration. LPN-B did not wiped off the stopper of the Novolog Flexpen and did not prime the pen. LPN-B wiped R76's abdomen with alcohol wipe and gripped skin to administer the Novolog. Surveyor stopped the administration and had LPN-B correctly prime the Novolog Flexpen. LPN-B did not wipe off the stopper on the Flexpen prior to attaching the needle. R76's quarterly MDS dated 10/15/15, indicated R76 was cognitively intact. Diagnosis identified on the MDS include diabetes mellitus. During interview on 12/16/15, at 12:37 p.m. interview LPN-B stated, I have never heard about priming a Flexpen. No one said we had to wipe the top. I thought it was sterile because it had a cap." During interview on 12/17/15, at 12:21 p.m. RN-B said it would not hurt to wipe the stopper off with alcohol, so yes. RN-B verified you are supposed	F 332		

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F 332	Continued From page 56	F 332		

to prime flex pens before you dial up the medication. RN-B stated I have not had education on Flexpen since I have been here.

During interview on 12/17/15, at 2:07 p.m. the IDON verified the process to give Insulin via a Flexpen: wipe off the end of the pen with alcohol, attach a needle, prime the pen with 2 units of insulin, dial up the dose required, take resident to room, explain process, administer the insulin. The IDON stated not priming the pen would result in the resident not getting the full dose. Not wiping the end of the pen off could result in an infection.

Discharged Resident Medication Transfer Record printed 12/17/15, for NovoLog Flexpen provided as manufacture insert. It instructed residents to "Learn all preparation and usage instructions from your healthcare professional and the product package."

NovoLog Flexpen manufacture guidelines dated April 2015, instruct users to "Step 1: Prepare your NovoLog Flexpen. Pull of the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from the needle and screw it onto your Flexpen tightly. Step 2: Step 2: Doing the air shot before each injection: small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to select 2 units. Hold your Flexpen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. If no drop

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F 332	Continued From page 57 appears, change the needle and repeat." R76 did not receive the full amount of insulin as ordered by the physician.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R76) were free of significant medication errors related to insulin administration this had the potential to affect 4 residents who receive insulin by insulin pens. Findings include: R76's Admission Record dated December 2015, indicated R76 had diagnosis of diabetes mellitus. R76's blood sugars between 12/1/15, and 12/16/15, ranged from a low of 115 to a high of 316. The Physicians Order for the period December 2015, directed staff to administer Novolog Flexpen (used to control blood sugar) 100 unit/milliliter sliding scale based three times a day with meals For blood sugar 150-200=4 units, 201-250=8 units 251-300= 12 units 301-350=16 units, 351-400= 20 units, blood sugar greater than 400 =24 units. During medication administration observation on 12/16/15, at 12:18 p.m. licensed practical nurse	F 333	F 333 On 12/28/2015 R76's blood sugars were reviewed and results were discussed with the diabetic clinic with no new orders noted. Resident is without any adverse effects noted related to this practice. A facility wide audit was complted on 12/28/2015 and sixteen residents have a potential to be affected. Nurisng staff will be in-serviced by 1/26/2016 and will include policies and procedures related to insulin injections, utilization of FlexPens, glucose monitoring and infection control. Audits will be completed by the DON and/or designee that will monitor identified residents requiring insulin injections three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	1/26/16

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F 333	Continued From page 58	F 333		

(LPN)-B verbalized R76's blood sugar was 223 and would need eight units of Novolog. LPN-B attached the needle to the Flexpen and dialed 8 units for administration. LPN-B did not wiped off the stopper of the Novolog Flexpen and did not prime the pen. LPN-B wiped R76's abdomen with alcohol wipe and gripped skin to administer the Novolog. Surveyor stopped the administration and had LPN-B correctly prime the Novolog Flexpen. LPN-B did not wipe off the stopper on the Flexpen prior to attaching the needle.

R76's quarterly Minimum Data Set (MDS) dated 10/15/15, indicated R76 was cognitively intact. Diagnosis identified on the MDS include diabetes mellitus.

During interview on 12/16/15, at 12:37 p.m. interview LPN-B stated, "I have never heard about priming a Flexpen. No one said we had to wipe the top. I thought it was sterile because it had a cap."

During interview on 12/17/15, at 12:21 p.m. registered nurse (RN)-B said it would not hurt to wipe the stopper off with alcohol, "so yes." RN-B verified you are supposed to prime Flexpen's before you dial up the medication. RN-B stated, "I have not had education on Flexpen since I have been here."

During interview on 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) verified the process to give Insulin via a Flexpen: wipe off the end of the pen with alcohol, attach a needle, prime the pen with 2 units of insulin, dial up the dose required, take resident to room, explain process, administer the insulin. The IDON stated

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F 333	Continued From page 59 not priming the pen would result in the resident not getting the full dose. Not wiping the end of the pen off could result in an infection. Discharged Resident Medication Transfer Record printed 12/17/15, for NovoLog Flexpen provided as manufacture insert. It instructed residents to "Learn all preparation and usage instructions from your healthcare professional and the product package." NovoLog Flexpen manufacture guidelines dated April 2015, instruct users to "Step 1: Prepare your NovoLog Flexpen: Pull of the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from the needle and screw it onto your Flexpen tight. Step 2: Step 2: Doing the air shot before each injection: small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to select 2 units. Hold your Flexpen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. If no drop appears, change the needle and repeat."	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		1/26/16

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F 371	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe and sanitary condition in the kitchen storage and food preparation areas. In additional, the facility failed to ensure hair restraints were worn. This had the potential to affect 71 of 72 residents in the facility who ate out of the kitchen. Findings include: On 12/16/15, at 2:09 p.m. during kitchen tour with nutrition services manager (NSM), the following was observed: -a ¼ quart full container of white milk and ¾ quart full container of chocolate milk, with no open for use date on them. -¾ full bag of open pasta noodles was observed. Although the facility found a used by date on the package, the package of noodles were left open without closure to prevent contamination of the noodles. During the entire tour through the kitchen, walk-in cooler, and freezer on 12/16/15, at 2:09 p.m. the NSM was observed to not be wearing a hair restraint to cover his beard. During the tour, NSM was also observed to bend down to lower shelves and lift individual baking pans to inspect them to ensure they were dry.	F 371	F 371 No residents were found to be affected by this practice; however, this had the potential to affect 71 of 72 residents in the facility on that day. All residents have the potential to affected by these practices that eat out of the kitchen. In-servicing will be provided to the dietary staff related to food storage and sanitary conditions and review policies and procedures related to infection control by the Nutrition Services Mangaer (NSM) and/or designee by 1/26/2016. Audits will be completed by the NSM and/or designee that will monitor sanitary storage in food prep areas, including wearing of hair nets, the cleaning schedule three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified and recommendations made for continued audits/monitoring needs.	

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F 371	Continued From page 61 On 12/17/15, at 10:22 a.m. the dirty dish area was observed. There were three empty dishwasher dish trays standing upright on their side on the floor in front of the dishwasher. The dietary aide removed an empty dishwasher tray from the floor, placed it on the dishwasher belt, and loaded it with dirty dishes. She then opened the dishwasher cover and pushed the clean dish tray to the outside by pushing the dirty dish tray onto the clean one. The NSM stated it was not sanitary to be done that way and informed the dietary aide. On 12/17/15, at 10:29 a.m. NSM stated the milk should have dates when opened for use. He stated the pasta noodles should have had a twist tie on the bag and be closed. On 12/17/15, at 10:32 a.m. NSM stated anyone working with food should wear a beard net. He stated if they were not mixing/working with food it was not necessary to wear one. He stated he would wear a net if he was cooking food and serving at the steam table. The 2013 Food and Drug Administration (FDA) Food Code under the section of Hair Restraints read, "(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." The facility sanitation procedures policy dated	F 371		

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F 371	Continued From page 62 July 2015, included "3. Wear a hair restraint at all times... Cover all of hair, including facial hair. Beards must be covered."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon for 1 of 5 residents (R68) reviewed for unnecessary medications. Findings include: R68's Care Area Assessment dated 4/24/15, indicated R68 received antipsychotic medications. The facility's consultant pharmacy report entitled, Consultation Report Omnicare of Minnesota dated 5/12/15, included: "receives an antipsychotic, and is reported to have fallen or be at high risk for falls... Please consider monitoring postural blood pressures (BP) at least	F 428	R68's consultant pharmacist recommendations to monitor postural blood pressures at least monthly was obtained and put into place on 12/28/2015. All residents have the potential to be affected by this same practice, however a facility wide audit was completed on 12/18/2015 and fourteen residents were identified at risk for monitoring needs for postural blood pressures. Nursing staff will be in-serviced by 1/26/2016 on policy and procedure for psychoactive medication symptom assessment/ care plan needs. Audits will be completed by the DON or	1/26/16

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F 428	Continued From page 63 monthly/assessing for orthostatic hypotension per facility policy (or as advised by prescriber)." The medical record lacked any evidence of this irregularity having been brought forward to the facility's attention again even though no orthostatic blood pressures for R68 had been completed since May of 2015. The Medication Administration Record (MAR) included an order dated 5/13/15, for orthostatic blood pressures to be completed monthly, if utilizing an antipsychotic. R68's MAR for May 2015 indicated monitoring of orthostatic blood pressures had not been completed. In addition, the medical record, which included the MAR and Treatment Administration Record, lacked evidence of any orthostatic blood pressures having been monitored between May and November of 2015. The facility provided R68's current care plan dated 5/15/15. The care plan lacked any interventions for adverse side effect monitoring for R68's use of Seroquel (an antipsychotic) or Zoloft (an antidepressant). Although there was an opportunity to have selected interventions appropriate for such monitoring, an entire section of the plan remained unchecked including: Repetitive physical movement, balance while sitting, hypotension, dizziness/vertigo, syncope, unsteady gait, fall in past 30 days, fall in past 31-180 days, hip fracture, swallowing problem, weight loss and orthostatic BP. R68's quarterly Minimum Data Set (MDS) dated 11/27/15, indicated R68 was cognitively intact and had diagnoses including: cerebrovascular accident, traumatic brain injury, anxiety, and	F 428	designee for identified residents to ensure adequate monitoring is in place weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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	245417	A. BUILDING _____ B. WING _____	12/17/2015

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F 428	Continued From page 64	F 428		

depression. R68 was independent with most activities of daily living and required supervision, and set up help only with locomotion off unit. The MDS also indicated R68 had been admitted to the facility on 4/16/15.

The signed Physician Orders for December 2015, indicated R68 received Seroquel 25 milligrams (mg) every morning, and 50 mg every evening for mood disorder. Staff were also to monitor for the risk of psychopharmacological medications and if noted staff were to document the information in the medical record and notify the medical doctor. The licensed nurses documented "O" for monitoring for the risk of psychopharmacological medications however, there were no documented orthostatic blood pressures as recommended by the pharmacist to help identify potential adverse side effects for the use of Seroquel.

On 12/17/15 at 9:39 a.m., registered nurse (RN)-B stated they did not monitor orthostatic blood pressures.

On 12/17/15 at 2:31 p.m., the consultant pharmacist stated she expected orthostatic blood pressures to be monitored at least monthly.

On 12/17/15 at 3:23 p.m., the interim director of nursing (IDON) stated she did not see documentation indicating orthostatic blood pressures were being monitored. The IDON confirmed she expected such monitoring to be implemented in accordance with the consultant pharmacist's recommendation.

The package insert information for Seroquel from

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F 428	Continued From page 65 AstraZeneca Pharmaceuticals, last revised 10/29/13, indicated one of the adverse side effects for Seroquel was orthostatic hypotension. The information included; "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose." The facility's policy Psychoactive Medication dated 7/15, directed staff to "Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Care Plan." R68's care plan dated 5/15/15, was void any symptoms to monitor for side effects.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		1/26/16

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F 431	Continued From page 66 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure expired medications/treatments were discarded in 3 of 3 medications rooms; the facility did not ensure outgoing (medications to be sent back to pharmacy or destroyed in 2 of 3 medication rooms. This had the potential to affect all 73 residents. The facility failed to ensure the medication storage refrigerator was cleaned and defrosted in 1 of 3 medication rooms. In addition, the facility did not ensure Fentanyl (narcotic) patches were accurately destroyed to prevent potential diversion for 2 of 3 residents (R29, R10). Also, the facility failed to ensure medication carts were locked for 1 of 6 medications carts that were observed. Findings include: Second floor medication room	F 431	The expired medications identified in the 3 medication rooms were discarded and medications requiring to be sent back to the pharmacy or destroyed was completed on 12/17/2015. The medication storage refrigerator located in the second floor medication room was cleaned and defrosted on 12/17/2015. A facility wide audit was completed on 12/18/2015 to ensure medication carts were locked and Fentanyl patches were accurately destroyed to prevent potential diversion, no additional findings were noted. All residents have the potential to be affected. Nursing staff will be in - serviced by 1/26/2016 on the policies and procedures	

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F 431	Continued From page 67 On 12/17/15, at 1:36 p.m. the medication room storage tour was completed with registered nurse (RN)-A who provided access to the medication room. Upon opening, the second cabinet the shelves were observed overflowing with multiple bottles, pill cards of various medications and treatments. A tote with multiple medications was observed stored under the sink, which appeared to have dry water stain and water damage. Some of medications were observed to either have brown drips on the cap or side unsure what the substance was. In addition, the following were observed: - 15 bottles of Iodoform (antiseptic wound packing stripes) stored inside the sink in the medication room of which some were in a box and four loosely lying inside the sink that had dried white soap scum all over the sink. RN-A verified and stated, "They is a better place to be store them. We do have a supply room." - Three Zinc 50 milligram (mg) high potency 100 tablets bottles with expiration 10/15. - Engerix B (hepatitis B medication) vials, eye drops and with acetaminophen suppositories stored together in a small tote. - one infusion ball device of nafcillin 100 mg (an antibiotic) stored in the refrigerator crisper drawer with a discard date after "12/11/15." On 12/17/15, at 1:52 p.m. RN-A verified the expired medications stated they were not supposed to be stored in the refrigerator. RN-A acknowledged and stated, "There is a lot of work that needs to be done." When asked how often medications were destroyed or sent back to the pharmacy to be disposed RN-A stated the last time it had been done was three months ago. When asked who was responsible for making	F 431	related to receipt and disposition of all controlled drugs, the storage of drugs, the process to discard expired drugs, drugs requiring to be returned to the pharmacy, and the monitoring and care related to the medication refrigerators including the cleaning and defrosting process. Audits will be completed by the DON or designee for all of the medication rooms, medication and treatments carts to ensure adequate monitoring is in place three times per week for one week. then weekly. In addition controlled drug audits will be completed to ensure Fentanyl patches were accurately destroyed to prevent potential diversion three times weekly for one week, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs.	

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F 431	Continued From page 68 sure expired medications were not stored in the medication room RN-A stated "The final responsibility is mine." When asked if medications were supposed to be stored together with suppositories RN stated they should have been stored separately. 2ND FLOOR REFRIGERATOR FREEZER On 12/17/15, at 1:54 p.m. during medication storage tour with RN-A the freezer was observed to have a two-three inch thick build up frost. Three ice packs were observed encased in the frost. In addition, the thick frost was observed to have an orange discoloration. RN-A stated the nurses on night shift were supposed to be cleaning and defrost the refrigerator and freeze once a month. Fentanyl patches disposal Second Floor: On 12/17/15, at 2:07 p.m. a tour of the medication cart was completed with RN-A During the tour inside the narcotic box was observed an opened box of Fentanyl patches for R29. When asked what the facility policy was for disposing used patches RN-A stated two nurses had to witness the destruction and both nurses were supposed to sign off on the Medication Administration Record (MAR). During review of R29's MAR and narcotic book, from 12/1/15 to 12/16/15, it was revealed R29 had received the Fentanyl patch five times, of which only three times two nurses had documented witnessing the destruction. Third Floor	F 431		

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F 431	Continued From page 69 On 12/17/15, at 2:30 p.m. RN-F provided access to the medication cart and the narcotic box. During the tour, three Fentanyl patches for R10 were observed stored inside the narcotic box. When asked what the facility policy was for destroying the used patches, RN-F stated two nurse were supposed to witness the destruction. RN-F verified R10 had the patch removed and destroyed six times from 12/1/15, to 12/16/15, of which four times did not have a second nurse sign off witnessing the destruction and one time no nurse had signed off on the MAR the destruction on 12/16/15. Third Floor medication room On 12/17/15, at 3:45 p.m. during a subsequent medication tour to the medication room with RN-F who provided access the following were observed: -Hemoccult (a test to look for blood in stool) test kit with expiration 5/2015, and three boxes of Anticoat absorbent wound dressing with expiration 1/2014, and other two 12/2013 all stored in a shelve in the medication room. In addition, the biohazard refrigerator was observed with two inches buildup frost. RN-F verified stated would be cleaned. When asked who was responsible for making sure the medication room was free of expired medications and treatments stated was the nurse manager and the other managers would help. Also on the second shelves of the refrigerator was observed Glycerin suppositories (bowel stimulant)stored together with insulin flex pens, and eye drops. When asked about medication storage RN-F stated was the policy to separate the medications.	F 431		

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F 431	Continued From page 70 On 12/17/15, at 2:57 p.m. the interim director of nursing (IDON) stated expired medications were supposed to be pulled from cart and medication room for destruction and suppositories were supposed to be stored separately from other medications. IDON further stated the nurses were supposed to follow the policy of two nurse sign when the patches are removed and destruction and the nurses were supposed to follow the policy for cleaning the refrigerators. Medications were not properly stored on one medication cart and two medication carts were not properly secured. Improperly stored medication: The medication cart was observed on 12/16/15 at 9:55 a.m. with RN-B. RN-B checked the 3rd floor treatment cart with RN-B and director of nursing (DON). Both nurses acknowledged the Santyl wound product was not separated from the oral medication. RN-B Stated "You are right, the Santyl was not placed in bag " and it was the only wound tube product in the drawer. The drawer contained two empty bags which with two different resident names. When asked what the risk was of using the same tube on two different residents RN-B replied, "If not handled right you might take something from one resident to another resident." A bottle of eye drops Voltaren (used for glaucoma) 1 % was dated as open on 2/17/14. RN-B stated [R87] was not receiving this treatment. RN-B stated if a medication or treatment is discontinued the nurses are to remove the ointment from cart.	F 431		

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F 431	Continued From page 71 Unlocked medication carts: On 12/16/15, at 11:53 a.m. licensed practical nurse (LPN)-B was observed to walk down to the nurses desk leaving the medication cart unlocked. - At 11:56 a.m. LPN-B returned and locked cart. No resident, staff or visitor had approached the cart. - At 12:05 p.m. the medication cart was left unlocked as LPN-B walked into resident room to perform a blood sugar test. LPN-B closed the door to R76's room. The medication cart was out of sight. - At 12:08 p.m. the LPN-B returned to the cart. No resident, staff or visitor had approached the cart while it remained unlocked. - At 12:10 p.m. through 12:13 p.m. LPN-B left medication cart unlocked on South hall way and went to help a resident wheel down the hall. No resident, staff or visitor had approached the cart while it remained unlocked. - At 12:26 p.m. LPN-B left R76's insulin pen with needle intact, on top of the medication cart while in dining room. The medication cart was not in nurse's reach or view. - At 12:37 p.m. LPN-B was interviewed and said, "I should not have left it there. I got rattled and yes, I forgot to lock the cart when I went down to see if R76 was around. I am not supposed to leave the cart unlocked. It is not how I normally do things." The medication cart contained various insulin product." On 12/17/15, at 12:21 p.m. RN-B stated, "Carts should be locked when the nurse is not with them. Insulin pens should not be left on top of med cart if nurse is not at the medication cart."	F 431		

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F 431	Continued From page 72 During interview on 12/17/15 at 2:07 p.m. IDON stated, "Med carts should be locked when the nurse is not there. There is risk for injury if they [residents] get in the cart." Destruction of Controlled Drugs effective July 2015, directed: "2. Destroy used transdermal patches, (e.g. Fentanyl), following removal from the resident. a. Two licensed nurses must sign for the destruction of the used patch on the resident's Medication Administration Record ..." Storage and Expiration of Medications, Biologicals, Syringes and Needles policy revised 1/1/13, directed: "3. General Storage Procedures: 3.2. Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biological. 3.4. The facility should ensure that infusion therapy products and supplies are stored separately from other medications and biologicals, under appropriate temperature and sterility conditions, according to the manufacturer's or supplier's recommendations. 16. Facility should destroy or return all discontinued, outdated/expired or deteriorated medications or biological in accordance with pharmacy return/destruction guidelines and other Applicable Law,..."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and	F 441		1/26/16

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F 441	Continued From page 73 transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow infection control precautions for 8 of 8 residents (R13, R76, R1,	F 441	Diabetic care: R13, R 76, R1, R132, R75, R31, R61, R14 clinical records were reviewed on	

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F 441	Continued From page 74 R132, R75, R31, R61, R14) reviewed for infection control. Findings include: Diabetic care: R13: On 12/14/14, at 6:04 p.m. licensed practical nurse (LPN)-D was observed come out of R13's room wearing a pair of gloves and had a glucometer in her hand. LPN-D disposed the lancet then grabbed the tip of the used stripe with blood disposed it in the sharps container, then took a SANI-PDI wipe (germicidal disposable wipes) that was on top of the treatment cart wiped the glucometer briefly wrapped it with wipe set the glucometer inside on the top drawer of cart. LPN-D then still wearing the same gloves picked a pen and documented in the treatment sheets. LPN-D then pulled the drawer with same gloves obtained an insulin vial drew insulin went to R13's room pulled the privacy curtain was overheard indicate to R13 she was going to give her insulin. LPN-D then came out of room with same gloves disposed the syringe then went into R13's wheeled resident out of room to the hallway then proceeded to wheel the cart down the hallway from last room in the south hallway to the last room in the north hallway still with same gloves on. The quarterly Minimum Data Set (MDS) dated 11/13/15, indicated R13 was a diabetic and had no infections. R76: On 12/14/14, at 6:10 p.m. LPN-D was observed	F 441	1/5/2016 for infection control purposes to ensure each resident was without infections at the time this practice was observed. No infections were noted. LPN-D, RN -G and RN-A verbalized correct infection control practice after 1:1 review(s) completed after observations were made on the specific dates noted. All residents have the potential to be affected by this practice as it relates to infection control, however a facility wide audit was completed on 12/28/2015 and sixteen residents with diagnosis of diabetes and who also have orders to monitor their blood sugars have the potential to be affected. Nursing staff will be in -serviced by 1/26/2016 and will include a review of the policies and procedures related to the use of personal protective equipment (PPE). Hand hygeine including the use of hand sanitizer, glucose monitoring equipment: disinfect/ decontaminate procedure and bloodborne pathogens related to infection control standards of practice. Audits will be completed by the DON or designee that will monitor infection control practices three times per week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs. Peri Care: NA-C verbalized understanding on 12/16/2015 related to the standards of practice when assisting R61 with pericare	

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F 441	Continued From page 75 look inside R76's room removed the gloves re-applied another pair without washing hands or using hand sanitizer went into R76's room set the glucometer on the bedside pull table without a barrier punctured the second finger obtained a drop of blood set the glucometer on the table again obtained a reading of 146. LPN-D ask R76 to wait for insulin. LPN-D went out of room cleaned the glucometer briefly with a Super SANI- PDI Cloth wipe then wrapped with the Super SANI-PDI Cloth and set it on the top cart drawer still with same gloves drew the insulin from vial and went to room shut the door, came out disposed the syringe with same gloves document still wearing the same gloves. R76's MDS dated 10/15/15, indicated R76 was diabetic and had no infections. R1: On 12/14/14, at 6:17 a.m. LPN-D then stated she was going to next to R1's room to do another blood sugar check. LPN-D still wearing the same gloves got to R1's room as she was going into the room surveyor intervened and asked nurse if she was supposed to wash her hands between gloves changes stated she usually would use the hand sanitizer then went into R1's room washed hands came out applied a pair of gloves. At 6:18 p.m. LPN-D went into room and set the glucometer on R1's left thigh and punctured the finger obtained a drop of blood got a reading of 108 came out of room removed the gloves after disposing the lancet and stripe into the sharps container took the gloves off, donned another pair of gloves without washing hands, recorded the reading then drew seven units of Novolog	F 441	needs. All residents who receive assist with hygeine needs have the potential to be affected. Nursing staff will be in - serviced by 1/26/2016 and will include a review of the policies and procedures related to use of personal protective equipment (PPE). Hand hygiene including the use of hand sanitizer, and infection control standards of practice. Audits will be completed by the DON or designee that will monitor infection control practices three times per week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs. Wound Care: On 12/16/2015 the pharmacy was notified and sent a new tube of Santyl to replace the soiled one. The wound care supplies were removed from the room and were replaced with new ones to ensure none were exposed to dirty linen. RN-B verbalized on 12/16/2015 understanding related to hand hygeine meeds and policy and procedure as it related to wound care. All residents who receive wound care have the potential to be affected. Nursing staff will be in -serviced by 1/26/2016 and will include a review of the policies and procedures related to the use of personal protective equipment (PPE). Hand hygiene including the use of hand	

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F 441	Continued From page 76 (medication used to control blood sugar) went into R1's room administered it on the left arm removed gloves outside the room and came back into the room and washed hands. At 6:22 p.m. when asked if she was supposed to wash her hands between residents and if she was supposed to wash her hands after glove change LPN-D stated "Yes. I was just rushing through as supper was coming up." LPN-D further stated "when I was trained we were trained to wipe the glucometer and wrap it and that's what I did as I was using them. I forgot the sanitizer in the other cart. It's ideal to wash with water or hand sanitizer." When asked about the barrier she acknowledged she had not used the barrier on R76's bedside table stated there was no blood all over the glucometer but acknowledged would have been ideal to use a barrier but was not sure as she would not remember if that had been addressed in the training and thought was sufficient to clean it after each use. When asked if she was supposed to walk down the hallway with used gloves LPN-D acknowledged she should have removed them. R1's MDS dated 11/24/15 indicated R1 was a diabetic and had no infections. R132 was observed on 12/15/15, at 11:44 a.m. Registered nurse (RN)-G was observed enter R132's room with a small tote which contained blood sugar supplies. Upon entering the room RN-G set the tote directly on the bedside pull table without a barrier and then got a paper towel retrieved a glucometer from the tote and set it next to the tote on the paper towel. After applied the stripe wiped R132's finger with alcohol then	F 441	sanitizer, wound care and treatment policy and procedure, and infection control standards of practice. Audits will be completed by the DON or designee that will monitor infection control practices three times per week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified and recommendations made for continued audits/ monitoring needs.	

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F 441	Continued From page 77 punctured it obtained a drop of blood and obtained a reading of 159. RN-G took gloves off tossed in garbage, came back gathered the supplies and LPN-E who was in the room at the rime took the glucometer wrapped in a paper towel brought it out of the room set it on the cart then then RN-G took the tote returned it into the third drawer without cleaning it then was observed wipe the glucometer tossed the wipe and then proceeded to get a Super SANI-PDI Cloth wipe wrapped around the glucometer and then washed her hands with the hand sanitizer. At 11:52 a.m. when asked if the tote was supposed to be placed directly on the bedside table and put back into the cart, RN-H and LPN-C present by the cart outside R132's room both stated the tote was supposed to have been cleaned on the bottom before it was stored. The nurses were all observed clean the cart and the tote. LPN-C stated she preferred the totes not to be taken into the rooms. R132's MDS dated 10/12/15 indicated R132 was a diabetic and had no infections. R13's blood sugar completion was observed on 12/16/15, at 7:38 a.m. LPN-B came in with gloves on and glucometer and supplies in hand to do blood sugar, LPN-B put glucometer on over bed table with no barrier, used the lancet device and obtained a blood sugar. LPN-B then removed her gloves, picked up supplies and let the room without washing hands. LPN-B entered the room with gloves on and gave insulin to R13, who was on the toilet. LPN-B left the room with gloves on.	F 441		

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F 441	Continued From page 78 R75's blood sugar observation was completed on 12/16/15, at 8:11 a.m. LPN-B was observed go into R75's room indicated was going to check the blood sugar came out applied gloves cleaned the glucometer with a Super SANI-PDI Cloth wipe briefly then went into the room and shut the door. LPN-B then obtained a paper towel and set it on the bedside pull table and set the glucometer, a whole bottle of glucometer stripes alcohol wipe and lancet. LPN-B then obtained one stripe from the bottle and applied to glucometer asked resident which finger then punctured it squeezed and obtained a drop of blood with reading of 134. LPN-B then still with the same gloves pick up the bottle of stripes (multiple-use) and the glucometer with used stripe on came out of the room tossed the bottle into the top drawer with all the supplies and clean glucometer's. Then cleaned the glucometer with the same gloves after touching the tip of the stripe with blood wrapped it then removed the gloves and used hand sanitizer. At 8:13 a.m. when asked about the bottle of stripes she had brought into the room and had touched it with the gloves stated "I should have not taken into the room and should have removed my gloves before touching it." LPN-B acknowledged she should have changed her gloves before cleaning the glucometer. R75's MDS dated 12/10/15, indicated R75 was a diabetic and had no infections. R31: On 12/14/15, at 11:59 a.m. RN-A entered R31's room with glucometer in hand. RN-A left the door open and placed glucometer on bedside table, washed R31's finger obtained blood. RN-A told	F 441		

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F 441	Continued From page 79	F 441		

R31the result of Blood sugar. RN-A returned to treatment cart,RN-A placed a paper towel on the treatment cart and wrapped glucometer in SANI-PDI wipe for two minutes.

R31's annual MDS dated 9/9/15, indicated R31 had diagnosis of diabetes which required daily insulin.

On 12/16/15, at 12:16 p.m. to 12:41 p.m. during an interview with the infection control RN-I when asked if she did go in with staff to observe cares RN-I stated she would go in and would go with the nurses during medication pass, "I have assigned a restorative aide to go in, and watch cares." RN-I stated staff had received training on the use of a barrier when using a glucometer in the resident room and staff was supposed to go with the supplies they needed only for the task as recommended by Centers for Disease Control (CDC). When asked if there was on-going training RN-I gave example of the glucometer cleaning training provided recently and indicated training is done on-line and staff had to have a check list checked off which the staff signed after she of the nurse had observed then complete the task appropriately. RN-I also stated staff had been trained "No gloves in the hallway" and training had been done for nursing assistant (NAs) on the use of personal protective equipment (PPE) and NA's had been trained to remove gloves, wash hands, put clean gloves again if coming in contact with fluids. RN-I stated she would expect the nurses to remove soiled gloves after removing the old dressing and wash hands then apply another pair to continue with the dressing change. Indicated the staff was supposed to go with the supplies they needed for

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F 441	Continued From page 80 the task as recommended by CDC. On 12/17/15, at 2:46 p.m. interim director of nursing (IDON) stated she would expect the nurses to not walk with gloves in the hallway, to have removed gloves, if gloves were soiled she expected the staff to wash hand and it not use hand sanitizer. IDON further stated the staff were supposed to follow policy with barrier use on bedside table when doing blood sugar checks. Pericare: R61 was observed being wheeled into her room by NA-C on 12/16/15, at 8:51 a.m. from the dining room. At 8:55 a.m. R61 was observed open the bathroom door then came out. At 8:56 a.m. R61 was overheard resident call out "pleas help" and NA-C was observed go to roo applied gloves and assisted resident into th toilet. R61 was heard void then stated "am d ne" NA-C then cued resident to stand then cue R61 he was going to apply a transfer belt aroun he wai then assisted resident to stand. NA-w observed use toilet pa r to wi e resident bottom twice which was noted to a brown stool then with the same gloves adjus d R61's incontinent pad and pants then guided re dent to seat on the wheelchair. NA-C still wearing the same gloves was heard indicate to R61 "you had a bowel movement." NA-C then touched the wheelchair armrests with the same gloves and as she wheeled resident through the door removed the gloves and wheeled resident to the sink located in the room and washed her hands and set resident to wash hands too. -At 9:02 a.m. When asked if she was supposed to wash her hands after providing pericare NA-C	F 441		

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F 441	Continued From page 81 stated "Am sorry I was supposed to remove the gloves." NA-C acknowledged she should have washed her hands also. -At 9:11 a.m. when asked if the staff were supposed to wash hands after providing pericare and if staff were supposed to change gloves during cares the IDON stated "Yes." At 9:12 a.m. surveyor asked RN-B to clean the wheelchair armrest. Glucose Monitoring Equipment: Disinfect/Decontaminate effective July 2015, directed staff "Place the glucometer on the overhead table on a clean surface, e.g paper towel, wax paper." For cleaning the glucometer the policy directed "1. Use the disinfectant wipe to clean all external parts of the glucometer with gloves on. 2. Remove gloves. 3. Perform hand hygiene. 4. Don clean gloves 5. Obtain a second wipe and fresh paper towel. 6. Use the wipe to clean all external parts of the glucometer for the second cleaning. 7. Place the glucometer on the fresh paper towel. 8. Remove gloves. 9. Perform hand hygiene. 10. Place glucometer in appropriate storage until next blood glucose test..." Hand Hygiene - Plain Soap and Water Handwash policy effective July 2015, directed: "A plain soap and water handwash will be used: · If hands are visibly soiled	F 441		

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F 441	Continued From page 82 · Before eating and after using the restroom · If exposure to spores is suspect or proven e.g, C. difficile A plain soap and water handwash or an alcohol hand rub may also be used: · If hands are not visibly soiled · Before having direct contact with residents · Before inserting indwelling catheters, peripheral vascular catheters, other invasive devices that do not require a surgical procedure · After contact with a resident's intact skin (e.g, when taking a pulse or blood pressure and lifting a resident) · After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if the hands are not visibly soiled · During resident care if moving from a contaminated- body site to a clean- body site · After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident · After removing gloves." R13's cares were observed on 12/16/15, at 7:38 a.m. R13 was then lifted to the stand platform and rolled (transported) from the bed to the bathroom. R13 was then lowered to the toilet. NA-C then performed pericare for R13, she then removed the gloves, but did not wash her hands. R13 was admitted to the facility 5/31/14, with admission diagnoses of stroke with hemiplegia (loss of use of one side of the body) dysphagia (difficulty swallowing food and liquids) and apraxia of speech (difficulty with expressing	F 441		

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F 441	Continued From page 83 thoughts). The quarterly MDS dated 11/13/15, indicated R13 was cognitively intact, moderately depressed and required extensive assist of two staff for transfer and toilet use. The annual Care Area Assessment (CAA) dated 3/6/15, indicated R13 was unable to participate in cares due to body habitus and refusals of care. R13 required assist of two staff and a stand assist lift to toilet, was usually incontinent and noncompliant with toileting schedule. The care plan dated 3/9/15, indicated assist of two staff with EZ stand for bed/chair/toilet. On 12/17/15, at 7:33 a.m. NA-C neither confirmed nor denied that she did not wash her hands when removing gloves. R14's pericare was observed on 12/16/15, at 9:37 a.m. NA-B washed R14's peri area from front to back and then washed R14's bottom. NA-B changed gloves but did not did not wash hands prior to putting on fresh new gloves. R14's MDS dated 12/8/15, indicated R14 required two person assist for toileting and personal hygiene and R14 had no behaviors of refusing care. Wound care: R14's MDS dated 12/8/15, indicated R14 was at high risk for pressure ulcers due to impaired bed mobility and impaired transfer. The MDS further noted R14 had an unstageable Stage 4 pressure ulcer. R14 required two person assist for transfers and bed mobility and had no behaviors	F 441		

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F 441	Continued From page 84 of refusing care. R14 wound care was observed on 12/16/15, at 9:28 a.m. It was noted that dressing supplies included a package of non sterile guaze, several 4x4 avino dressings, and a bottle of spray wound cleanser. There was a bag of dirty linen on top of the bucket of clean dressing supplies. RN-B applied gloves and removed the soiled dressing. The dressing was dated 12/15/15, and had a dark stain on out side of dressing. RN-B did not wash their hands after they removed the soiled dressing nor did they change gloves. RN-B opened a new dressing with the soiled gloves and placed the dressing (still in its package) on the bed side table. RN-B placed Santyl (wound care product) on bedside table without a barrier. RN-B placed tape pieces on bed, then placed the dressing package on mattress. RN-B applied Santyl to the dressing the soiled gloves and then placed the Santyl tube on mattress (without a barrier). RN-B removed the soiled gloves and applied new gloves but did not wash their hands. RN-B applied dressing and dated it. RN-B removed gloves, did not wash hands, placed the tube of Santyl ointment in pocket. RN-B removed bag of soiled dressing supplies to the soiled utility room and washed their hands at 9:42 a.m. During interview on 12/16/15, at 9:45 a.m. RN-B verified the Santyl product was in the uniform pocket. RN-B stated, "No, I should have not put it on the bed. In a perfect world you would want to put down on a sterile sheet." RN-B also acknowlwdged the policy indicated to use a barrier such as a paper towel. "I should have placed it there instead of my pocket." RN-B	F 441		

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F 441	Continued From page 85 placed Santyl in treatment cart from the now soiled pocket. RN-B also acknowledged the lack of handwashing after the removal of the soiled dressing. During interview on 12/17/15, at 2:07 p.m. the IDON stated, "It is not ok to place Santyl on a bed or bedside table without a barrier, or in your pocket and take to the soiled utility room and then place in the treatment cart. Residents should have their own tube of santle with their name on the tube or container in which it is contained. I expect the nurses to remove gloves after a soiled dressing change and wash hands or use sanitizer."	F 441		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ice machines and microwaves were in good operating condition. This had the potential to affect 71 of 72 residents in the facility who ate out of the kitchen. Findings include: On 12/15/15, at 10:27 a.m. the second floor dining room ice machine was observed to be slowly dripping near the spout and the grate had a small area of white stain. In addition, the microwave had a small amount of food spilled on	F 456	F 456 Microwaves have been replaced, and the ice machines were cleaned on 12/15/2015. Microwaves are utilized in the three dining rooms. Ice machines are on an on-going cleaning schedule. Staff will be in-serviced by 1/26/2016 as it relates to the policies and procedures of sanitary conditions related to the ice machines and the microwaves.	1/26/16

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F 456	Continued From page 86 the inside food plate. On 12/15/15, at 10:25 a.m. nutrition services manager (NSM) stated he would check with the manufacturer regarding the ice machine. He also confirmed the ice machine was due to be cleaned and was cleaned on Tuesdays. He stated the microwave needed to be cleaned which was done daily. On 12/15/15, at approximately 10:28 a.m. NSM stated where ice formed inside the ice machine, it did not make a seal and dripped. He stated as the ice melted inside the machine it dripped through, and confirmed it dripped on the front of the third floor dining room machine near the spouts. On 12/15/15, at 10:33 a.m. the fourth floor dining room microwave was observed to have the enamel plastic casing chipped and worn off on the inside door and inside front opening. NSM confirmed it should not be used and removed it from service. In addition, he stated the ice machine had a drip and did not have a gasket. As the ice began to melt it dripped and indicated he would check with the manufacturer. On 12/16/15, at 9:57 a.m. NSM stated they have three filters on the ice machines which were cleaned yesterday. On 12/16/15, at 3:20 p.m. the ice machines were observed to still be dripping. Facility nutrition services microwave procedure dated July 2015 indicated "will be maintained in a clean and sanitized condition... will be wiped out	F 456	Audits will be completed by the NSM and/or designee that will monitor the cleaning schedule three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified and recommendations made for continued audits/monitoring needs.	

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F 456	Continued From page 87 after each use and thoroughly cleaned twice per week or more often as needed." Facility nutrition services ice machine procedure dated July 2015 indicated "the ice machine, scoop, and storage container will be maintained in a clean and sanitary condition. The ice machine will be cleaned once per month or more often as needed." MDT5N25 & MDT5N40 user manual dated November 2008 indicated "the dispense area: spouts, sink, grill and splash panel will need periodic cleaning and maintenance. 2. The sink grill may be removed for washing and sanitizing." Undated dining services cleaning schedule indicated third and fourth floor microwaves were to be cleaned daily and the ice machines were to be cleaned weekly.	F 456		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an environment that was clean and in good repair 3 of 13 residents (R87, R43, R82). This also had the potential to affect 1 of 3 floors in which there were 13 of 26 residents who potentially could be affected for the South shower on third floor.	F 465	F 465 Areas identified on the environmental tour on 12/16/2015 which included the shower room, the grab bar, the wheelchair, and the privacy currtain were all corrected immediately upon identification. The shower door will be corrected by	1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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F 465	Continued From page 88 Findings include: On 12/16/15, at 10:37 a.m. to 11:53 a.m. the environmental tour was conducted with the maintenance supervisor (MS), executive director (ED), housekeeping supervisor (HKS), executive director in training and housekeeping and laundry manager (HKLM). During the tour the following concerns that had been identified during stage I of the survey were verified: R87's grab bars secured to bed on 12/14/15, at 4:11 p.m. during room observation were observed to be padded with porous black uncleanable foam which was secured with black tape. The black tape was noted to be wrinkled and not creating a seal which exposed the adhesive part and rendered the foam portion to be an uncleanable surface. During the tour the executive director verified it and stated the grab bars would be replaced with lamb wool skin which can be washed and would provide padding to resident. R87's quarterly Minimum Data Set (MDS) dated 10/27/15, indicated R87 required extensive assist with bed mobility and transfers. R43's right wheelchair armrest was observed to be in ill-repair on 12/15/15, at 8:15 a.m. The vinyl was chipped which exposed the mesh underneath, making it an uncleanable surface, was observed with a thin coating of dust on the entire frame of the wheelchair and the seat was observed ripped/torn on the sitting part both the MS and ED verified stated would replace the seat and MS stated armrest would be changed. When	F 465	1/26/2016. A facility wide audit was completed and any areas identified will be corrected by 1/26/2016. Staff will be in-serviced by 1/26/2016 as it relates to the policies and procedures of environmental needs. Audits will be completed by the Director of Maintenance and Director of Housekeeping and/or designee that will monitor the shower rooms, grab bars, wheelchairs, and privacy curtain cleanliness, and shower room doors once a week for three weeks, and monthly thereafter. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

REVISED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	12/17/2015

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ROBBINSDALE REHAB & CARE CENTER	**3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422**

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F 465	Continued From page 89 asked how often the wheelchairs were cleaned MS and HKS stated deep cleaning was done monthly and at the time if any concerns was identified would be reported to MS to address and as needed. R43's quarterly MDS dated 9/11/15, indicated R43 had severely impaired cognition, was independent with transfers after set up and used a wheelchair and walker for locomotion. R82's privacy curtain on 12/14/15, at 2:04 p.m. had a large yellow stain on it. During the tour ED and housekeeping and laundry manager verified the yellow substance on the privacy curtain. When asked how often the privacy curtains were changed the housekeeping and laundry manager stated was done daily by housekeeping staff during the daily room cleaning and were changed as needed. R82's quarterly MDS dated 10/6/15, indicated R82 had severely impaired cognition and was occasionally incontinent of urine. R82 required one person assist with transfers, bed mobility and toileting. South Shower rooms During the environmental tour conducted on 12/16/15, at 10:37 a.m. to 11:53 a.m. the both the shower rooms were observed with the following concerns: -The bottom of left shower room door was observed to have extreme water damage which caused the entire edge length to crack all along it.	F 465		

REVISED

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F 465	Continued From page 90 -The shower room on the right was observed to have white yellow gooey substance on the soap holder on the wall, had a missing towel holder with some parts still screwed on the wall, the privacy curtain behind the door was observed to have multiple stains of brown matter. During the tour the housekeeping supervisor verified the findings. When asked how often the privacy curtains were changed the housekeeping and laundry supervisor stated was checked daily as the shower room was cleaned daily and never indicated if the shower was cleaned between residents. She also indicated the curtains were changed as needed. The executive director verified the missing towel holder. Wheelchair Safety Checks policy effective July 2015, indicated "The center strives to check wheelchairs regularly foot proper operation and safety. When clinical or non-clinical staff notice loose hardware or other possible safety issues with the operation of a wheelchair the resident should be removed from the potentially unsafe wheelchair, the wheelchair taken out of operation, and repair personnel should be contacted. The appropriate repair person will be notified. Regular preventative maintenance checks on wheelchairs will be performed monthly by the maintenance Department..."	F 465		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by:	F 468		1/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 468	Continued From page 91 Based on observations and interview, the facility failed to ensure all handrails were firmly secured to walls. This had the potential to affect 1 of 3 floors in which there were 20 of 26 residents who either were ambulatory or were in a wheelchair who used the handrails to propel themselves. Findings include: 3 North Hallway On 12/16/15, at 8:11 a.m. R76 was observed leave the dining room never took his walker with him and went out of the dining room to the hallway and was observed ambulate to his room as he grabbed the handrails along the hallway across from the DR and went into his room. -At 8:12 a.m. surveyor observed the screw of th handrail located right across from the dining room to be loose. When surveyor approached and touched the handrail, it was observed to be loose and not adhered to the wall for stability. On 12/16/15, at 10:37 a.m. to 11:53 a.m. during the environmental tour the concern was brought to the facility attention and the maintenance supervisor (MS) verified the handrail was loose and immediately tightened the handrail. MS stated "Am very disappointed in myself. I walk through this hallways and check."	F 468	F 468 The handrail identified as being loose was tightened on 12/16/2015 during the environmental tour. A faciltiy wide audit was completed and other areas identified were corrected immediately. Staff will be inserviced on environmental needs related to handrails being firmly secured. Audits will be completed by the Director of Maintenance and/or designee that will monitor once a week for three weeks, and monthly thereafter. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

REVISED

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B1TG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00122

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245417**
2.STATE VENDOR OR MEDICAID NO.
(L2) **516842200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ROBBINSDALE REHAB & CARE CENTER**
(L4) **3130 GRIMES AVENUE NORTH**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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) **07/01/2015**

6. DATE OF SURVEY **12/17/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **75** (L18)
13.Total Certified Beds **75** (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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	75			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 01/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 02/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(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.
06301
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN 24 5417

Documentation supporting the facility's request for a continuing waiver involving LSC K67 is being recommended and forwarded to CMS for approval.

MDH
Minnesota
Department
of Health

Electronically delivered
January 4, 2016

Ms. Kathleen Pankratz, Administrator
Robbinsdale Rehab & Care Center
3130 Grimes Avenue North
Robbinsdale, MN 55422

RE: Project Number S5417025

Dear Ms. Pankratz:

On December 17, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

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 January 26, 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 January 26, 2016 the following remedy will be imposed:

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

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

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

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to ensure of 2 of 2 residents (R82, R87) who were assessed not to self-administer medication. Findings include: R82 was observed on 12/14/15, at 7:03 p.m. to have a clear plastic medication cup on the table in front of R82 with four medications in it. There were two blue and white capsules, one dark colored capsule and a white oval that had the word Renvela (prevent hypocalcemia-low levels	F 176	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by January 26, 2016.	1/26/16

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

Electronically Signed | 01/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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F 176	Continued From page 1 of calcium in the body) printed on it. There were three other residents seated at the table. The medication cup remained at the table throughout the evening meal until R82 self-administered the medications at 7:25 p.m. Licensed practical nurse (LPN)-D was noted to leave the dining room area at the time of the observation and was not in a location where able to visualize R82. Self-medication and Data Collection and assessment dated 8/31/12, and reviewed 5/11/13, was marked not applicable and indicated resident requested staff to administer medication. Quarterly Nursing Data Collection and Assessment dated 10/5/15, indicated no for "self-medicates/desires to self-medicate." R82's quarterly Minimum Data Set (MDS) dated 10/6/15, indicated R82 was moderately cognitively impaired and had diagnoses of dementia, diabetes and chronic kidney disease stage 4 on dialysis. Nursing Comprehensive Admission Data dated 12/6/15, indicated no for R82 had no desire to self-administer the medication. The Hennepin County Medical Center Discharge orders printed 12/6/15, indicated R82 was to take one Nephrocap (a combination of B vitamins used to treat or prevent vitamin deficiency due to poor diet, certain illnesses) 1 milligram (mg) capsule by mouth in the afternoon, two Phoslo capsules (used to treat high levels of phosphate in patients with chronic renal failure) 667 mg each three times a day with meals and Renvela 800 mg by mouth three times daily with meals. There was no physician order or care plan for R82 to	F 176	A Self Medication and Data Collection and assessment was completed for R82 on 1/5/2016 in order to evaluate R82's ability to safely self-administer her medications. The results were reviewed by the interdisciplinary team (IDT) prior to implementation to determine if the practice is safe. Licenced Practical Nurse (LPN) D was provided education on 12/15/2015 related to self-sdminister drug management procedure to ensure LPN -D follows correct procedure when administering medications. A Self Medication and Data Collection and assessment was completed for R87 on 1/5/2016 in order to evaluate R87's ability to self-administer her medications. The results were reviewed by the IDT to determine if the practice is safe. LPN-D was provided education on 12/15/2015 related to self-administration management procedure when administering medications. All residents have the potential to be affected by the same deficient practice. A facility wide audit was completed on 12/17/2015 and 19 residents were identified with current self- administration of medications and will be re evaluated by 1/26/2016. Measures and systematic changes made to ensure that the deficient practice will not re occure include reviewing new	

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	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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F 176	Continued From page 2 self-administer medications. R87 was observed on 12/14/15, at 7:03 p.m. to have a clear plastic medication cup on the table in front of R87 with two white tablets in it. There were three other residents seated at the table. The medication cup remained at the table throughout the evening meal until R82 self-administered the medications at 7:20 p.m. LPN-D was noted to leave the dining room area at the time of the observation and was not in a location where able to visualize R87. On 12/16/15, at 2:07 p.m. a bottle of Nystatin powder (used to treat fungal skin infections) was observed on an end table in R87's room. Self-Medication and Data Collection and Assessment dated 5/10/14, was marked not applicable and indicated resident will allow nursing staff administer medication. Quarterly Nursing Data Collection and Assessment dated 10/27/15, indicated no for "self-medicates/desires to self-medicate." R87's quarterly MDS dated 10/27/15, indicated R87 was severely cognitively impaired and had diagnoses of dementia and heart failure. The Physicians Orders for period December 2015 listed Tylenol Extra Strength (a mild analgesic) 2 caplets (1000 mg) by mouth three times a day. There was no Physician Order for Nystatin powder on order sheets. There was no Physician Order or care plan for R87 to self-administer medications.	F 176	admissions prior to the plan of care (POC) meeting, held within 21 days of admissioni. Current in house residents will be reviewed during the facility weekily comprehensive care plan review meetings per the assigned schedule. All Registered Nurses (RN) and LPN's will be in serviced on policy and procedure by 1/26/2016. Audits will be completed weekly x 4 weeks by the DON and/ or designee that will monitor identified residents for the ability to self-administer drugs. The DON and/ or her designee will complete audits with RN's and LPN's related to self-medication. Audits will be reviewed during the quality Assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs.	

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F 176	Continued From page 3	F 176		

During interview on 12/15/15, at 11:55 a.m. LPN-D stated, "Yes, I left the pills on the table last night for them. They both like to take their pills with meals. If you give them their pills when they are in their room, they will bring it to the dining room. I do not know if they have self-administration of medication orders." LPN-D verified the medications left for R82 were two Phoslo capsules, on Renvela tablet and one Nephrocap. LPN-D verified the medication left for R87 were two Tylenol 500 mg tablets.

On 12/17/15, at 12:28 p.m. registered nurse (RN)-B verified R82 and R87 do not have self-administration orders, assessments or care plans. The nurse should not have left the medications with them.

During an interview on 12/17/15, at 2:07 p.m. when asked would you expect nurses to leave a cup of medications on the dining room table for a resident who does not have a self-administration of medication order, the interim director of nurses (IDON) said, "No, they have to have all three: an assessment, an order and a care plan." The IDON verified R82 and R87 could not safely self-administer medications.

Self Medication Assessment and Management Procedure dated July 2015, instructed staff:
The facility used the Self Medication and Data Collection and Assessment form to evaluate the resident's ability to self medicate safely.
"1. Review resident's request to self medicate" and
"7. Determine outcome of the assessment.
a. Resident able to safely self-administer medications.
* All questions must be marked "able" for

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F 176	Continued From page 4 resident to self-administer b. Resident unable to self-administer medications at this time. Document the reason and plan for re-evaluation as appropriate."	F 176		
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). 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	F 225		1/26/16

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F 225	Continued From page 5 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 an allegation of resident to resident verbal abuse for 1 of 3 residents (R4) reviewed for abuse. Findings include: R4's quarterly Minimum Data Set dated 11/12/15, indicated R4 was moderately cognitively impaired without signs or symptoms of delirium, hallucinations, delusions or behaviors and required assistance with all activities of daily living. Diagnoses included on the MDS included: cerebral palsy, anemia, seizures, anxiety, depression, schizophrenia, sleep apnea and functional quadriplegia. During an initial interview on 12/14/15 at 1:58 p.m., R4 was asked, "Has staff, a resident or anyone else here abused you - this includes verbal, physical or sexual abuse?" R4 answered, "Yes." When asked to explain R4 said verbal abuse, R4 stated, "There is another resident who is swearing at me all the time." When asked did you tell staff R4 said, "Yes, the nurse." However, R4 was unable to identify which nurse he'd told. When asked if had seen other residents being abused he said the other resident swears at other residents.	F 225	The initial self report was completed for R4 on 12/17/2015 when the facility was made aware of the alleged resident to resident alligation and a through investigation was immedicately initiated. The results of the investigation in accordance with state law were reported on 12/22/2015 which was within 5 working days of the report. On 12/23/2015 the facility received confirmation from the state survey and certification agency which reads, "On 12/17/2015 the office of heaLth facility complaints, (OHFC) recieved a report of possible maltreatment. The track ID for this report is 90981. As you are aware the vulnerable adult act MN statute 626.557; requires us to notify you regarding the initial disposition of the report. The information has been reviewed and it has been determined that no further action is necessary at this time." All residents have the potential to be affected. Measures put into place include staff education will be completed by 1/26/2016. Three residents will be selected randomly	

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F 225	Continued From page 6 During follow up interview on 12/17/15, at 9:52 a.m. R4 said, "The resident swore at me but I don't know if he is still here." R4 stated he felt safe here. When asked if the staff intervene when swearing occurs R4 said, "Yes and no." When asked to explain what he meant, R4 was unable to elaborate. When asked if R4 had told a staff member he stated, "Yes." When asked if he could name the staff member, R4 said it was a nurse's aide. R4 was unable to name or describe the aide he'd told. When R4 was asked when the swearing had occurred, R4 did not answer. When asked if it happened in the fall, R4 said "Yes." When asked if it happened last fall or this fall, R4 said, "This fall." On 12/17/15, at 10:38 a.m. nursing assistant (NA)-C was interviewed and stated R4 had not reported another resident's swearing at him. NA-C stated, "I have not seen any one swear at him." On 12/17/15, at 12:47 p.m. registered nurse (RN)-B stated R4 had never told him that another resident had sworn at him. RN-B added, "I have not heard any one swear at him." When asked if the resident made false accusations RN-B replied, "Not that I can think of I have never heard him make an accusation against anyone. If this had been reported to me, I would find out what happened, try to find the root of it and would determine a plan to protect him." RN-B also remarked he would let the facility staff know and if it continued he would bring it to the interdisciplinary team. On 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) and DON in training were interviewed. When informed by the surveyor of	F 225	for audits that will be completed by the Administrator and/or designee on a weekly basis for two weeks and the results will be reviewed at the monthly QA meeting to determine if any rends are identified, and recommendations made for continued audits/monitoring needs.	

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F 225	Continued From page 7 R4's allegation of verbal abuse, due to another resident swearing at him all the time, the IDON stated, "No one told me about [R4's]an allegation that a resident was swearing at him." The IDON then informed the surveyor, "I'm going to get together with [R4] and see what he can tell me, and then do a self-report to the State." The IDON also stated, "I'll do an incident report and then do an investigation and write a five day report." On 12/21/15, at 1:53 p.m. the facility faxed information to the state survey team post survey which indicated they'd conducted an investigation into the alleged verbal abuse however, the report indicated the facility had not reported the allegation of abuse to the SA's Office of Health Facility Complaints prior to initiating an investigation. On 12/22/15, at 11:00 a.m. the state's Office of Health Facility Complaints was contacted and verified they had not received a report from the facility regarding R4's allegation of resident to resident verbal abuse. The facility's policy, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property dated July 2015, included: "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies and Adult Protective Services, as required... Identification 1. Identify events, such as resident-to resident altercations, bruising of residents, occurrences, patterns, and trends that may constitute abuse, neglect, and/or mistreatment.	F 225		

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F 225	Continued From page 8 2. Instruct staff, resident, family, visitor, etc., to report immediately, without fear of reprisals, any knowledge of abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property... Reporting 1. Notify the Shift Supervisor/Charge Nurse immediately if allegations of abuse, neglect, mistreatment or misappropriation of resident property occurs. 2. Report the incident immediately to the Executive Director and DON [director of nursing]/designee, Who will immediately report any allegations of mistreatment, neglect abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and other agencies. a. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident, in absence of a shorter state time frame requirement. 3. Create the eAI [electronic accident/incident] report upon identification of alleged abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property... 4. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the 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.	F 226		1/26/16

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F 226	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their policies to immediately report allegations of abuse to the State agency (SA) in 1 of 3 Residents (R4) reviewed for abuse. Findings include: The facility's policy, Prevention and Reporting: Resident Mistreatment, Neglect, Abuse, Including Injuries of Unknown Source and Misappropriation of Resident Property dated July 2015, included: "All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies and to all other agencies including the local law enforcement, elder abuse agencies and Adult Protective Services, as required... Identification 1. Identify events, such as resident-to resident altercations, bruising of residents, occurrences, patterns, and trends that may constitute abuse, neglect, and/or mistreatment. 2. Instruct staff, resident, family, visitor, etc., to report immediately, without fear of reprisals, any knowledge of abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property... Reporting 1. Notify the Shift Supervisor/Charge Nurse immediately if allegations of abuse, neglect, mistreatment or misappropriation of resident property occurs. 2. Report the incident immediately to the	F 226	The initial self report was completed for R4 on 12/17/2015 when the facility was made aware of the alleged resident to resident allegation and a thorough investigation was immediately initiated. The results of the investigation in accordance with State law were reported on 12/22/2015 which was within 5 working days of the report. On 12/23/2015 the facility received confirmation from the State survey and cerification agency which reads, "On 12/17/2015 the office of health facility complaints, (OHFC) received a report of possible maltreatment. The track ID for this report is 90981. As you are aware the vulnerable ault act MN statute 626.557; requires us to notify you regarding the initial disposition of hte report. The information ahs been reviewed and it has been determined that no further action is necessary at this time." All residents have the portential to be affected. Measures put into place include staff education will be completed by 1/26/2016. Staff will be selected randomly for audits that will be completed on a weekly basis for 2 weeks by the Administrator and/or designee and the results will be reviewed at the monthly QA meeting to determine if	

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F 226	Continued From page 10 Executive Director and DON [director of nursing]/designee, Who will immediately report any allegations of mistreatment, neglect abuse, including injuries of unknown source, and misappropriation of resident property to applicable state and other agencies. a. 'Immediately' means as soon as possible, but not to exceed 24 hours after discovery of incident, in absence of a shorter state time frame requirement. 3. Create the eAI [electronic accident/incident] report upon identification of alleged abuse, neglect, mistreatment, injuries of unknown source, and/or misappropriation of property... 4. Report all alleged violations and all substantiated incidents to the state agency and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation." R4's quarterly Minimum Data Set dated 11/12/15, indicated R4 was moderately cognitively impaired without signs or symptoms of delirium, hallucinations, delusions or behaviors and required assistance with all activities of daily living. Diagnoses included on the MDS included: cerebral palsy, anemia, seizures, anxiety, depression, schizophrenia, sleep apnea and functional quadriplegia. During an initial interview on 12/14/15, at 1:58 p.m. R4 was asked, "Has staff, a resident or anyone else here abused you - this includes verbal, physical or sexual abuse?" R4 answered, "Yes." When asked to explain R4 said verbal abuse, R4 stated, "There is another resident who is swearing at me all the time." When asked did you tell staff R4 said, "Yes, the nurse." However, R4 was unable to identify which nurse he'd told.	F 226	any trends are identified, and recommendations made for continued audits/monitoring needs.	

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When asked if had seen other residents being abused he said the other resident swears at other residents.

During follow up interview on 12/17/15, at 9:52 a.m. R4 said, "The resident swore at me but I don't know if he is still here." R4 stated he felt safe here. When asked if the staff intervene when swearing occurs R4 said, "Yes and no." When asked to explain what he meant, R4 was unable to elaborate. When asked if R4 had told a staff member he stated, "Yes." When asked if he could name the staff member, R4 said it was a nurse's aide. R4 was unable to name or describe the aide he'd told. When R4 was asked when the swearing had occurred, R4 did not answer. When asked if it happened in the fall, R4 said "Yes." When asked if it happened last fall or this fall, R4 said, "This fall."

On 12/17/15, at 10:38 a.m. nursing assistant (NA)-C was interviewed and stated R4 had not reported another resident's swearing at him. NA-C stated, "I have not seen any one swear at him."

On 12/17/15, at 12:47 p.m. registered nurse (RN)-B stated R4 had never told him that another resident had sworn at him. RN-B added, "I have not heard any one swear at him." When asked if the resident made false accusations RN-B replied, "Not that I can think of I have never heard him make an accusation against anyone. If this had been reported to me, I would find out what happened, try to find the root of it and would determine a plan to protect him." RN-B also remarked he would let the facility staff know and if it continued he would bring it to the interdisciplinary team.

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F 226	Continued From page 12 On 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) and DON in training were interviewed. When informed by the surveyor of R4's allegation of verbal abuse, due to another resident swearing at him all the time, the IDON stated, "No one told me about [R4's]an allegation that a resident was swearing at him." The IDON then informed the surveyor, "I'm going to get together with [R4] and see what he can tell me, and then do a self-report to the State." The IDON also stated, "I'll do an incident report and then do an investigation and write a five day report." On 12/21/15, at 1:53 p.m. the facility faxed information to the state survey team post survey which indicated they'd conducted an investigation into the alleged verbal abuse however, the report indicated the facility had not reported the allegation of abuse to the SA's Office of Health Facility Complaints prior to initiating an investigation. On 12/22/15, at 11:00 a.m. the state's Office of Health Facility Complaints was contacted and verified they had not received a report from the facility regarding R4's allegation of resident to resident verbal abuse.	F 226		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced	F 257		1/26/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBBINSDALE REHAB & CARE CENTER	3130 GRIMES AVENUE NORTH ROBBINSDALE, MN 55422

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F 257	Continued From page 13 by: Based on observation, interview and document review, the facility failed to ensure comfortable temperature was maintained in 1 of 3 dining rooms (Three South). This had the potential to affect 25 of 26 residents who used the dining in the unit. Findings include: 3rd floor North dining room On 12/14/15, at 6:30 p.m. to 7:10 p.m. during a dining room observation the dining room was noted to be very warm. At the time of the observation 11 residents were in the dining room (DR) waiting for the food and then they got served. As residents waited for food, R46 and R61 were seated at the far table, close to door and were overheard to state the room was very hot. On 12/15/15, at 8:25 a.m. during the breakfast meal R165 was overheard to indicate to R13 the DR was hot which was the other side of the split DR. R13 nodded her head as she wiped her forehead with her napkin. R13's Minimum Data Set (MDS) dated 10/22/15, indicated had impaired cognition impairment however, R13 had the ability to express their needs and understand others. R61's Minimum Data Set (MDS) dated 11/25/15, indicated had impaired cognition impairment however, R61 had the ability to express their needs and usually understand others. R165's Minimum Data Set (MDS) dated 12/9/15, indicated had moderate cognition impairment	F 257	Staff offered to remove the sweater of R61, which was declined. The fan mounted on the wall in the dining room was cleaned immediately during the environmental tour on 12/16/2015. All residents have the potential to be affected. Staff will be in-serviced on actions they can take when residents verbalize concerns related to temperatures, e.g. statements such as, "It's hot in here" by 1/26/2016. The pnuematic thermostats are being re-calibrated to create a more comfortable environment for the residents. Audits will be completed by the Director of Maintenance and/or designee 3 times a week times 2 weeks, then weekly times 2 weeks to monitor air temperatures in various locations. The dining room fans will be audited by the housekeeping supervisor or designee to ensure they are cleaned per the cleaning schedule. The results will be reviewed at the monlthly QA meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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F 257	Continued From page 14	F 257		

however, R165 had the ability to express their needs and understand others.

R13's MDS dated 11/13/15, identified R13 as having intact cognition and was able to express their needs.

On 12/16/15, at 7:40 a.m. R61 was observed to have removed her sweater shortly after being brought into the DR for exercises. During the exercises R61 kept dozing on and off and at 7:59 a.m. restorative staff approached asked R61 "You look tired do you want to stay for breakfast or go take a nap" R61 stated "What time is it. It's hot in here." Restorative staff then wheeled R61 to the table offered to remove her sweater completely but R61 stated "Just leave it."

On 12/16/15, at 10:37 a.m. to 11:53 a.m. the environmental tour was conducted with the maintenance supervisor (MS), executive director, housekeeping supervisor, executive director in training and housekeeping and laundry manager. During the tour, the DR window had been cracked open. Even with the window cracked open, the temperature reading of the DR was 82.7 degrees. In addition, the other split DR side temperature was reading 81.5 degrees and MS stated it was hard to regulate the temperature in the building with the fluctuating outside temperatures. MS acknowledged the temperature was high. When asked to close the DR window, the MS declined to close the window as there were residents in the DR and MS thought the DR room was "hot."

In addition a fan mounted on the wall in the DR was observed to have fluffy gray black matter build-up on the on the fan grates. During the tour

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F 257	Continued From page 15 the fan was noted to be running and blew air into the dining room directly onto the tables where residents sat during meals. When asked how often the fan was cleaned the housekeeping and laundry manager stated every other month. When asked when the fan in the DR had been cleaned last housekeeping and laundry manager stated she was not sure as the previous manager was responsible for overseeing the cleaning was done. Housekeeping and laundry manager stated she had not been at the facility for three months and thought would have been cleaned in August 2015, last. On 12/16/15, at 11:56 a.m. a copy of the facility policy was requested but not provided.	F 257		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278		1/26/16

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F 278	Continued From page 16 willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R98) Minimum Data Set (MDS) was coded accurately reviewed for urinary incontinence. Findings include: R98's admission MDS dated 7/25/15, indicated resident had been coded as occasionally incontinent and on the subsequent quarterly MDS dated 10/23/15, had been coded as being frequently incontinent which indicated a decline in bladder continence. The Urinary incontinence Care Area Assessment (CAA) dated 7/27/15, indicated resident had occasional bowel and bladder incontinence since admission, had several aspects that played into it such as being new to facility, had recently had a major surgery and took a diuretic which increased the chance of incontinence. The CAA had also indicated R98 was alert and oriented and was able to ask for assistance and had the potential for independence with toileting as well as continence of bowel and bladder. R98's care plan dated 10/15, identified resident	F 278	R98 Quarterly MDS ARD dated 10/23 was reviewed on 12/17/2015 and a modification was completed on 1/6/16. Resident was discharged on 11/1/2015. All residents have the potential to be affected by this practice. The IDT will receive the re-education MDS accuracy standards per the RAI manual by 1/26/2016. Re-education will be conducted by the Regional Director of Revenue Integrity and/or designee. The DON and/or designee will educate the nursing staff by 1/26/16 on resident documentation. The Regional Director of Revenue Integrity and/or designee will audit three MDS's per month for a period of three months to validate accuracy. The facility's IDT weekly comprehensive care plan review (CCPR) meeting will be utilized to validate accuracy of MDS coding after the MDS has been completed. Results of audits will be reviewed at the faciity's QA meeting monthly until resolved.	

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had an alteration in urinary continence the care plan directed staff to complete care tracker three-day elimination tracking to determine a voiding pattern, complete bladder data collection and assessment among others.

R98's diagnoses included arthritis, cerebrovascular accident, abnormal gait, hip joint replacement, and muscular wasting and was obtained from quarterly MDS dated 10/23/15.

R98's undated Bladder Data Collection And Assessment indicated resident was continent. and on the undated Bowel Data Collection and Assessment was indicated resident was continent and used a diuretic.

On 12/17/15, at 12:52 registered nurse (RN)-E, the MDS coordinator, after she pulled the data used to code the MDS's stated during the admission MDS with assessment dates 7/19/15 through 7/25/15, R98 had three episodes of incontinence during the time frame and that was why he was coded as occasionally incontinent. The quarterly MDS dated 10/23/15, with assessments dates 10/17/15 to 10/23/15, noted R98 to have had six episodes of incontinence which put him to be coded as frequently incontinent. The MDS coordinator stated R98 had a surgery on 10/9/15, and came back to the facility on 10/12/15, and the quarterly MDS was done within two weeks post surgical. When asked about the undated assessment which indicated R98 was continent the MDS coordinator stated she was not sure and acknowledged she had co-signed them and stated was going to follow up with the licensed practical nurse-C if resident had been put on a toileting program.
-At 2:34 p.m. the RN-E approached and stated

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F 278	Continued From page 18 the quarterly MDS had been coded based the data that nursing assistants had documented in care tracker and did not realize it was mistaken data at the time and acknowledged resident was supposed to have been coded as occasionally incontinent as the admission MDS. RN-E acknowledged the quarterly MDS had been coded inaccurately and stated would follow up with the consultant to see if MDS could be modified. -At 3:03 p.m. interim director of nursing (IDON) stated the nurses were supposed to analyze the data and follow up with data and ask questions to make sure the data was accurate if there was a change and then follow up with a notation the information was accurate. IDON stated the MDS was going to be modified and was going to follow up with the nurse.	F 278		
F 282 SS=E	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 review, the facility failed to ensure the plan of care was implemented for 1 of 3 residents (R91) reviewed for ADL's; for 1 of 3 residents (R14) reviewed for repositioning; for 1 of 3 residents (R72) for standard of tube feeding and for 1 of 3 residents (R61) reviewed for non-pressure related skin issues.	F 282	Shaving: R91 was given extensive assist with his shaving needs on 12/18/2015. A facility wide audit was completed on 12/18/2015 and seventeen male residents are noted to require extensive assist with shaving needs. In-servicing will be provided to all staff by	1/26/16

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F 282	Continued From page 19 Findings include: Shaving: R91 was not shaved according to the plan of care. R91 was observed to be sitting in the wheelchair (w/c) in his room on 12/14/15, at 3:52 p.m. and the resident face was covered with facial hair. When R91 was asked about be shaved, he stated "I shave every morning" and "it disturbed him to be seen by a young lady unshaven." On 12/16/15, at 8:49 a.m. R91 was in the dining room (DR) eating breakfast and still was observed to be unshaven. On 12/17/15, at 7:45 a.m. and 1:07 p.m. R91 was seated in the area lounge and remained unshaven. R91's care plan dated 10/25/15, indicated R14 required extensive assist of two with personal hygiene which included combing of hair, shaving, dressing and undressing. On 12/17/15, at 12:43 p.m. registered nurse (RN)-B was interviewed and indicated R91 did not look like he got shaved. R91 did not receive the care and services according to the plan of care for personal hygiene as he remained unshaved from 12/14 15 through 12/17/15. Repositioning: Physician's Order signed 11/30/15, indicated staff were to "Reposition every 2 hours in bed and every 1 hour in chair." R14's Skin Integrity Assessment:Prevention and Treatment Care Plan undated, instruct staff to implement an individualized turning schedule in applicable "q [every] 2 hrs [hours]", to lay R14 on	F 282	12/26/2016 that address the need to provide services by qualified persons in accordance with each residents plan of care (POC). Staff in-servicing will also address direct observation and actions to be taken if residents are observed to be unshaven. Audits will be completed by the DON and / or designee that will monitor identified residents requiring assist with shaving three times a week for two weeks, then weekly. The weekly audits will be completed during facility caring partners rounds. Audits will be reviewed during the QA meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs. Repositioning: R14 elected hospice services and the POC and phsician orders were reviewed and updated on 1/5/2016. A facility wide audit was completed on 12/18/2015 with eight residents identified that require assist with repositioning based on physician recommendations. In - servicing will be provided to all nursing staff by 1/26/2016 that addresses need to provide services by qualified persons in accordance with each residents POC. Staff in - serviceing will also include a review of the skin integrity assessment prevention program and treatment POC. Audits will be completed by the DON and/or designee that will monitor identified	

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F 282	Continued From page 20 the left side while in bed but not at all times, and to turn R14 with two pillows slightly high on side. W/c positioning per medical doctor (MD) order. R14 was not repositioned every two hours according to the plan of care. On 12/16/15, R14 was observed for repositioning and the following was noted: - At 9:45 a.m. was up in the w/c with speech therapy in DR. - At 10:30 a.m. the resident was her room seated in the w/c. - At 10:45 a.m. the resident in lounge playing dice. - At 12:17 p.m. R14 was asleep in w/c in DR. - At 12:25 p.m. R14 was awake sitting at the table in the DR. - At 1:32 p.m. R14 was placed in her bed. R14 went for three and 45 minutes without being repositioned. On 12/16/15, at 12:25 p.m. R14 was interviewed and was asked if she had laid down. R14 replied, "I have not been to bed. I did not refuse. I would have preferred to sleep in my bed. I did enjoy the dice game. They said I need to eat." - At 12:30 p.m. nursing assistant (NA)-G was interviewed and stated, "I have not laid her [R14] down yet. - At 12:31 p.m. a second NA was interviewed and NA-H, remarked, "No, I have not laid her down she was playing dice and it is lunch now." - At 1:32 p.m. RN-B, stated, "[R14] did not go to bed between breakfast and just now. We ideally only keep her up a couple of hours at a time. I have not seen her refuse to lay down." On 12/17/15, at 10:38 a.m. NA-F stated R14 would ask for assistance when she needs to use	F 282	residents requiring assist with repositioning three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs. G-Tube placement: R72's Orders and POC was reviewed on 12/17/2015 as it relates to G-tube placement, medication administration and nutritional formula tube feeding administration. Resident recieves bolus feedings, which he tolerates without signs or symptoms of adverse affects, to allow him increased independence rather than have a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolus tube feedings, g-tube placement verification and G-tube medication administration on 12/28/2015. A facility wide audit was completed on 12/17/2015 and four residents were identified that have the potential to be affected by this practice. In-servicing will be provided to staff by 1/26/2016 that addresses standards of practice as it relates to G-tubes and tube feedings. Audits will be completed by the DON and/or designee that will monitor identified residents requiring G-tube placement	

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F 282	Continued From page 21 the bathroom facilities. R14 was to be repositioned every two hours from left to right and she did not refuse to bed. - At 10:52 a.m. NA-H stated R14 was to be repositioned every two hours and sometimes when R14 was in the chair the aide(s) would lay her down after meals. - At 12:33 p.m. RN-B stated the wound doctor here and the doctor noted the wound was better. RN-B remarked, "Staff normally turn and reposition her every two hours. She is compliant with turning and reposition. No one came and told me we were having problems." RN-B indicated the wound had been present for over three months. During interview on 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) stated, "A resident who has a stage 4 pressure ulcer [e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers] to be repositioned based on physician recommendations, what is on their MDS and care plan." The IDON stated, "R14 should not have stayed up from 9:45 a.m. to 1:30 p.m. without being repositioned. I would expect staff to follow the care plan and physician orders." G-tube placement: R72's gastrostomy tube (G-tube) was not checked for placement according to the plan of care. R72's medication administration observation and enteral feeding via R72's G-tube was observed from 8:34 a.m. until 9:27 a.m. RN-D was observed to flush the G-tube with 100 cubic centimeters (cc) of water without first checking	F 282	checks, medication and tube feeding administrations, three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs. Skin alteration: An assessment was completed and monitoring was put into place on 12/16/2015 for R61 related to identified non-pressure skin issues. All residents have the potential to be affected by the same practice. Education will be provided to staff as it relates to monitoring and reporting observations to the team member qualified to provide the necessary services by 1/26/2016. Audits will be completed by the DON and/or designee weekly for residents identified to have non-pressure skin issues to ensure monitoring is in place. Audits will be reviewed during the qulity assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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placement. RN-D then continued to administer medications via drawing them up into a syringe and pushing them into the G-tube. After administering medications RN-D flushed the G-tube with 50 cc of water and drew up 50 cc of Jevity (a calorically dense nutritional formula for tube feeding) 1.5 with a syringe and pushed it into the G-tube. RN-D repeated that action until 225 cc of Jevity had been given. RN-D flushed the G-tube with 50 cc of water than gave the medication omeprazole (for gastroesophageal reflux disease-GERD) and flushed the G-tube with 50 cc of water.

The Nutrition Risk Care Plan dated 10/8/14, listed as nutritional risk factors were cardiac disease, risk of dehydration, low sodium levels, R72 typically consumed approximately 10 percent (%) of meals, swallowing difficulty due to squamous cell cancer of the throat, and requires tube feedings. The interventions directed staff to check for tube placement prior to feeding and medication administration.

R72's diagnoses listed on the December 2015 Physician Orders included dysphagia, malignant neoplasm of the mouth, GERD, and stroke. In addition, the orders directed staff to check for G-tube placement prior to feeding and medication administration.

On 12/17/15, at 9:27 a.m. RN-D verified the gastrostomy tube placement should have been checked before giving the medication or tube feeding. RN-D stated they had never given gastrostomy tube medications or feedings via gravity through a syringe, "that is old practice."

During interview on 12/17/15, at 2:07 p.m. the

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F 282	Continued From page 23 IDON stated, "I would expect the nurses to prepare the medications, go into the room and explain what they are doing to the resident, Check placement and check residuals, if ok, separate the plunger from the syringe, flush the tube and then pour each individual medication into the syringe flushing between meds. When done flush the tube, remove gloves and wash hands. You can mix all the meds if you have a doctor's order." R72's plan of care was not followed for the checking of the placement of the g-tube. Skin alteration: R61's skin alteration was not monitored according to the plan of care. R61 was interviewed on 12/14/15, at 1:52 p.m. and during the interview R61 pulled up her left sweater sleeve and two old bruises were observed. When asked if someone had abused her R61 denied but added the staff rushed through cares/assisting her. On 12/16/15, at 7:10 a.m. R61 was observed all dressed had a sweater on seated on the w/c wheeling herself into the day room. When asked how she had slept R61 stated good but her arm was hurting at the time and thought was from arthritis. - At 7:30 a.m. to 7:40 a.m. R61 was observed asleep on her w/c on the far corner of the table and R61 had removed her sweater. There were bruises noted on the left arm fading and another fading bruise noted on the right arm. - At 7:45 a.m. restorative assistant (RA) approached R61 offered to join the exercise and wheeled her into the group.	F 282		

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	245417	A. BUILDING _____ B. WING _____	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 24 - At 7:59 a.m. RA approached asked R61 "You look tired do you want to stay for breakfast or go take a nap?" The resident stated "What time is it? It's hot in here." The RA then wheeled R61 to the table offered to remove her sweater completely but resident stated "just leave it." Bruises were visible. -At 8:08 a.m. resident at the table eyes closed. -At 8:15 a.m. to 8:50 a.m. observed resident eating breakfast. R61's skin integrity assessment: preventation and treatment care plan dated 8/14/14, indicated resident was at risk related to impaired/decreased mobility, was incontinent of bowel and bladder and was at risk for bruising due to the use of Aspirin (used to treat mild to moderate pain and to reduce fever or inflammation). The care plan directed staff to inspect the skin for signs and symptoms of breakdown. An Occurrence Report dated 12/16/15, (after concern had been brought to the attention of facility staff by the surveyor), indicated R61 had several bruises/skin conditions to both arms. The note indicated the measurements of the bruises/skin conditions were as follows: - Right posterior forearm 2 centimeter (cm) x 1.6 cm resembled a bruise; - Right posterior lateral forearm 0.6 cm x 0.8 cm brown scaly lesion; - Right posterior distal upper arm 1.4 cm x 1.4 cm purple in color and scaly; - Right forearm proximal posterior lateral 0.6 cm x 0.6 cm purple and irregular shape; - Left lateral distal forearm 0.8 cm x 0.6 cm pink area; - Left posterior mid forearm 0.6 cm x 0.1 cm	F 282		

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F 282	Continued From page 25 scabbed lesion; - Left lateral upper arm 0.6 cm x 0.4 cm irregular purple discoloration; - Left posterior proximal forearm 0.8 cm x 0.4 cm lesion. On 12/16/15, at 2:33 p.m. RN-B stated he would expect the staff to report any changes in skin condition to the nurse if identified with cares when asked if it included any bruising. At 2:35 p.m. surveyor and RN-B went to room approached R61 who was seated on her wheelchair in her room. When RN-B started to look at R61's arms R61 stated "the kids make me get them because they grab me." RN-B verified the bruises on both arms stated the bruises were old bruises and was not able to describe some of the changes. On 12/17/15, at 7:56 a.m. the IDON stated an investigation had been started yesterday 12/16/15, after the concern had been brought to the facility attention and she thought resident was prone to bruising related to prophylactic Aspirin use, the way resident would position herself when in the common area and wheeling self around. When asked even though staff had identified possible causes if still any bruising was supposed to be investigated she indicated "Yes." The Pressure Ulcer CAA lacked R61's risk for bruising due to wheeling self around and positioning self as indicated by the IDON. On 12/17/15, at 3:00 p.m. IDON stated she would expect the NAs to report any change in skin to the nurse as soon as they are done with cares and the nurse needs to follow the facility protocol. The care plan for R61 was not followed for the observation of the changes in skin integrity.	F 282		

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F 282	Continued From page 26 Wound Preventation and Management Clinical Program Manual effective July 2015, directed "Monitor area(s) of skin impairments e.g. abrasion, bruise, burn, excoriation, or rash daily using the Treatment Administration Record until healed..."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess for root cause and provide preventative measures to prevent bruising for 1 of 3 residents (R61) reviewed for non-pressure related skin issues. Findings include: On 12/14/15, at 1:52 p.m. during the interview R61 pulled up her left sweater sleeve and two old bruises were observed. On 12/16/15, at 7:10 a.m. R61 was observed all dressed had a sweater on seated on the wheelchair (w/c) wheeling herself into the day room. When asked how she had slept R61 stated good but her arm was hurting at the time and thought was from arthritis.	F 309	F 309 An assessment was completed and monitoring was put into place on 12/16/2015 for R61 related to identifed non-pressure skin issues. All residents have the potential to be affected by the same practice. Education will be provided to staff as it relates to monitoring and reporting observations related to skin alteration(s) to the team member qualified to provide the necessary services by 1/26/2016. Audits will be completed by the DON and/or designee weekly for residents identifed to have non-pressure skin issues	1/26/16

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F 309	Continued From page 27 - At 7:30 a.m. to 7:40 a.m. R61 was observed asleep on her w/c on the far corner of the table and R61 had removed her sweater. There were bruises noted on the left arm fading and another fading bruise noted on the right arm. - At 7:45 a.m. restorative assistant (RA) approached R61 offered to join the exercise and wheeled her into the group. - At 7:59 a.m. RA approached asked R61 "You look tired do you want to stay for breakfast or go take a nap?" The resident stated "What time is it? It's hot in here." The RA then wheeled R61 to the table offered to remove her sweater completely but resident stated "just leave it." Bruises were visible. -At 8:08 a.m. resident at the table eyes closed. -At 8:15 a.m. to 8:50 a.m. observed resident eating breakfast. On 12/16/15, at 8:51 a.m. observed nursing assistant (NA) wheel resident out of the dining room her room then NA-C stated "I will see you later" resident stated "thank you" as resident wheeled self into her room." - At 8:55 a.m. observed resident open the door to bathroom, then came out. - At 8:56 a.m. overheard resident call out "please help" NA-C was observed go to room assisted resident into the toilet. NA-C assisted R61 to use the toilet and after applied a transfer belt around the waist and transferred R61 to wheelchair sweater still off never asked R61 about the bruising wheeled resident through the door out of the toilet to the sink area located in the room and set resident to wash hands too. Bruises were visible. R61's skin integrity assessment: preventation and treatment care plan dated 8/14/14, indicated	F 309	to ensure monitoring is in place. Audits will be reviewed during the quality assurance (QA)meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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F 309	Continued From page 28	F 309		

resident was at risk related to impaired/decreased mobility, was incontinent of bowel and bladder and was at risk for bruising due to the use of Aspirin (used to treat mild to moderate pain and to reduce fever or inflammation). The care plan directed staff to inspect the skin for signs and symptoms of breakdown.

R61's Pressure ulcer Care Area Assessment dated 3/19/15, indicated R61 was at risk for pressure related issues due to being dependent in mobility and activities of daily living.

R61's diagnoses included dementia non-Alzheimer's disease, seizure disorder/epilepsy, anxiety, osteoarthritis, osteoporosis, depressive disorder obtained from the quarterly Minimum Data Set (MDS) dated 11/25/15. In addition, the MDS indicated R61 had severely impaired cognition.

An Occurrence Report dated 12/16/15, (after concern had been brought to the attention of facility staff by the surveyor), indicated R61 had several bruises/skin conditions to both arms. The note indicated the measurements of the bruises/skin conditions were as follows:
- Right posterior forearm 2 centimeter (cm) x 1.6 cm resembled a bruise;
- Right posterior lateral forearm 0.6 cm x 0.8 cm brown scaly lesion;
- Right posterior distal upper arm 1.4 cm x 1.4 cm purple in color and scaly;
- Right forearm proximal posterior lateral 0.6 cm x 0.6 cm purple and irregular shape;
- Left lateral distal forearm 0.8 cm x 0.6 cm pink area;
- Left posterior mid forearm 0.6 cm x 0.1 cm

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F 309	Continued From page 29	F 309		

scabbed lesion;
- Left lateral upper arm 0.6 cm x 0.4 cm irregular purple discoloration;
- Left posterior proximal forearm 0.8 cm x 0.4 cm lesion.

On 12/16/15, at 2:30 p.m. NA-C was unavailable for interview to determine if the bruises were noted during morning cares.

On 12/16/15, at 2:33 p.m. registered nurse (RN)-B stated he would expect the staff to report any changes in skin condition to the nurse if identified with cares when asked if it included any bruising. At 2:35 p.m. surveyor and RN-B went to room approached R61 who was seated on her wheelchair in her room. When RN-B started to look at R61's arms R61 stated "the kids make me get them because they grab me." RN-B verified the bruises on both arms stated the bruises were old bruises and was not able to describe some of the changes.

On 12/17/15, at 7:56 a.m. the Interim director of nursing (IDON) stated she thought resident was prone to bruising related to prophylactic Aspirin use, the way resident would position herself when in the common area and wheeling self around. IDON indicated the Pressure Ulcer CAA lacked R61's risk for bruising due to wheeling self around and positioning self as indicated by the IDON.

On 12/17/15, at 3:00 p.m. IDON stated she would expect the NAs to report any change in skin to the nurse as soon as they are done with cares and the nurse needs to follow the facility protocol.

Wound Preventation and Management Clinical

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F 309	Continued From page 30 Program Manual effective July 2015, directed "Monitor area(s) of skin impairments e.g. abrasion, bruise, burn, excoriation, or rash daily using the Treatment Administration Record until healed..."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure removal of facial hair was provided for 1 of 3 residents (R91) reviewed for activities of daily living and who was dependent on staff for shaving. Findings include: R91 was observed to be sitting in the wheelchair in his room on 12/14/15, at 3:52 p.m. and the resident face was covered with facial hair. When R91 was asked about be shaved, he stated "I shave every morning" and "it disturbed him to be seen by a young lady unshaven." On 12/16/15, at 8:49 a.m. R91 was in the dining room eating breakfast and still was observed to be unshaven. On 12/17/15, at 7:45 a.m. and 1:07 p.m. R91 was seated in the area lounge and remained unshaven. The Nursing Notes were reviewed from 10/23/15	F 312	F 312 R91 was given extensive assist with his shaving needs on 12/18/2015. A facility wide audit was completed on 12/18/2015 and 17 male residents are noted to require extensive assist with shaving needs. In-servicing will be provided to all staff by 1/26/2016 that addresses need to provided to all staff by 1/26/2016. that addresses need to provide services by qualified persons in accordance with each residetn's POC. Staff in-servicing will also address direct observation and actions to be taken if residents are observed to be unshaven. Audits will be completed by the DON and/or designee that will monitor identified residents requiring asssit with shaving three times a week for two weeks, then weekly. The weekly audits will be	1/26/16

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F 312	Continued From page 31 going forward, and the Nursing Notes were void of any refusals of care. R91's care plan dated 10/25/15, indicated R14 required extensive assist with personal hyigene which included combing of hair, shaving, dressing and undressing. The Minimum Data Set (MDS) dated 10/30/15, indicated R91 received extensive two person assist for personal hygiene. The MDS also noted R91 had no behaviors of refusal of care and the cognition level was severely impaired. On 12/17/15, at 10:52 a.m. nursing assistant-D stated, "told the manager 'yes [R91 needed to be shaved]' and the manager was going to go back and do it." On 12/17/15, at 12:43 p.m. registered nurse-B was interviewed and indicated R91 did not look like he got shaved. R91 did not receive the care and services for personal hygiene as he remained unshaved from 12/14 15 through 12/17/15. During interview on 12/17/15, at 2:07 p.m. the interiem director of nursing stated, "If a resident is asked about being shaved and says yes or requests to be shaved, I expect the staff to attempt to do it the same day unless the resident changes their mind. I would expect them to document if the resident refused when asked."	F 312	completed during facility Caring Partners rounds. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	
F 314 SS=D	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	F 314		1/26/16

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F 314	Continued From page 32 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, facility failed to ensure 1of 3 (R14) residents who had been identified at risk for pressure ulcers receive assistance with repositioning. Findings include: R14's Minimum Data Set (MDS) dated 12/8/15, indicated R14 was at high risk for pressure ulcers due to impaired bed mobility and impaired transfer. The MDS further noted R14 had an unstageable Stage 4 pressure ulcer (full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) R14 required two person assist for transfers and bed mobility and had no behaviors of refusing care. According to the wound sheets the following was noted: - On 11/25/15, unstageable ulcer (full-tissue thickness loss in which the base of the ulcer was covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) measured 2.8	F 314	F314 R14 elected Hospice services and the POC and physician orders were reviewed and updated. A facility wide audit was completed on 12/18/2015 with six residents identified that require assist with repositioning based on physician recommendations who also have pressure ulcers. In-servicing will be provided to nursing staff by 1/26/2016 that addresses a review of the skin integrity assessment prevention program and treatment POC for residents identified with repositioning and pressure ulcer treatment needs. Audits will be completed by the DON and/or designee that will monitor identified residents requiring assist with repositioning and pressure ulcer treatments three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommmendations made for continued audits/monitoring	

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F 314	Continued From page 33 centimeters (cm) X 1.4 cm X 0.4 cm and healing well with no slough noted. - On 12/2/15, unstageable ulcer measured 2.8 cm X 1.4 cm X 0.4 cm and no change from last week. - On 12/9/15, unstageable ulcer measured 2.4 cm X 0.6 cm X 0.4 cm and healing well with no slough noted. - On 12/15/15, unstageable ulcer measured 2.4 cm x 0.6 cm x 0.4cm and granulation noted with no drainage. Pink in color. R14's Skin Integrity Assessment:Prevention and Treatment Care Plan undated, instruct staff to implement an individualized turning schedule in applicable "q [every] 2 hrs [hours]", to lay R14 on the left side while in bed but not at all times, and to turn R14 with two pillows slightly high on side. Wheelchair (w/c) positioning per medical doctor (MD) order. Physician's Order signed 11/30/15, indicated staff were to "Reposition every 2 hours in bed and every 1 hour in chair." On 12/16/15, R14 was observed for repositioning and the following was noted: - At 9:45 a.m.R14 was up in the w/c with speech therapy in dining room (DR). - At 10:30 a.m. the resident was her room seated in the w/c. - At 10:45 a.m. the resident in lounge playing dice. - At 12:17 p.m. R14 was asleep in w/c in DR. - At 12:25 p.m. R14 was awake sitting at the table in the DR. - At 1:32 p.m. R14 was placed in her bed. R14 went for three and 45 minutes without being repositioned.	F 314	needs.	

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F 314	Continued From page 34 On 12/16/15, at 12:25 p.m. R14 was interviewed and was asked if she had laid down. R14 replied, "I have not been to bed. I did not refuse. I would have preferred to sleep in my bed. I did enjoy the dice game. They said I need to eat." - At 12:30 p.m. nursing assistant (NA)-B was interviewed and stated, "I have not laid her [R14] down yet. - At 12:31 p.m. a second NA was interviewed and NA-D, remarked, "No, I have not laid her down she was playing dice and it is lunch now." - At 1:32 p.m. registered nurse (RN)-B stated, "[R14] did not go to bed between breakfast and just now. We ideally only keep her up a couple of hours at a time. I have not seen her refuse to lay down." On 12/17/15, at 10:38 a.m. NA-C stated R14 would ask for assistance when she needs to use the bathroom facilities. R14 was to be repositioned every two hours from left to right and she did not refuse to bed. - At 10:52 a.m. NA-D stated R14 was to be repositioned every two hours and sometimes when R14 was in the chair the aide(s) would lay her down after meals. - At 12:33 p.m. RN-B stated the wound doctor here and the doctor noted the wound was better. RN-B remarked, "Staff normally turn and reposition her every two hours. She is compliant with turning and reposition. No one came and told me we were having problems." RN-B indicated the wound had been present for over three months and the facility measured the wound weekly. During interview on 12/17/15, at 2:07 p.m. the interiem director of nursing stated, "If a resident is	F 314		

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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 35 asked about being shaved and says yes or requests to be shaved, I expect the staff to attempt to do it the same day unless the resident changes their mind. I would expect them to document if the resident refused when asked."	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube (G-tube) prior to infusing medication and formula for 1 of 1 resident (R72) observed to have a tube feeding during the survey.	F 322	F 322 R72's Order and POC was reviewed on 12/17/2015 as it relates to G-tube placement, medication administration and nutritional formula tube feeding administration. Resident recieves bolus	1/26/16

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	245417	A. BUILDING _____ B. WING _____	12/17/2015

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F 322	Continued From page 36 Findings include: During medication administration observation and enteral feeding via R72's G-tube from 8:34 a.m. until 9:27 a.m. registered nurse (RN)-D was observed to flush the G-tube with 100 cubic centimeters (cc) of water without first checking placement. RN-D then continued to administer medications via drawing them up into a syringe and pushing them into the G-tube. After administering medications RN-D flushed the G-tube with 50 cc of water and drew up 50 cc of Jevity (a calorically dense nutritional formula for tube feeding) 1.5 with a syringe and pushed it into the G-tube. RN-D repeated that action until 225 cc of Jevity had been given. RN-D flushed the G-tube with 50 cc of water than gave the medication omeprazole (for gastroesophageal reflux disease-GERD) and flushed the g-tube with 50 cc of water. The Nutrition Risk Care Plan dated 10/8/14, listed as nutritional risk factors: cardiac disease, risk of dehydration, low sodium levels, (R72) typically consumed approximately 10 percent (%) of meals, swallowing difficulty due to squamous cell cancer of the throat, and requires tube feedings. The interventions directed staff to check for tube placement prior to feeding and medication administration. Nutritional Status care area assessment dated 8/18/15, indicated R72 received the majority of nutrition via feeding tube and was at risk for unsafe weight changes, dehydration and aspiration or choking. R72's quarterly Minimum Data Set dated	F 322	feedings, which is tolerated without sign or sympotms of adverse affects, to allow increased independence rather than have a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolus tube feedings, g-tube placement verification and G-tube medication administration on 12/28/2015. A facility wide audit was completed on 12/17/2015 and four residetns were identified that have the potential to be affected by this practice. In-servicing will be provided to nursing staff by 1/26/2016 that addresses standards of practice as it relates to G-tubes utilizing facility policies and procedures as well as the CMS tube feeding status critical element pathway tool. Audits will be completed by the DON and/or designee that will monitor identified residents requireing G-tube placement checks, medicaiton and tube feeding administrations, three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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11/12/15, indicated R72 was cognitively intact and received "51 % or more" of his total calories through the feeding tube."

R72's diagnoses listed on the December 2015 Physician Orders included dysphagia, malignant neoplasm of the mouth, GERD, chronic obstructive pulmonary disease, and stroke. In addition, the orders directed staff to check for G-tube placement prior to feeding and medication administration.

On 12/17/15, at 9:27 a.m. RN-D verified the gastrostomy tube placement should have been checked before giving the medication or tube feeding. RN-D stated they had never given gastrostomy tube medications or feedings via gravity through a syringe, "that is old practice."

During interview on 12/17/15, at 9:33 a.m. RN-A stated the nurse should have checked placement and residuals before giving anything by a G-tube. RN-A verified when a nurse administered medication by a G-tube they would flush the G-tube with water then add water to the crushed medications, take the syringe apart, pour the medication in the syringe. "You might have to keep adding water to the cup to make sure you get it all the medication. You would then do liquid medications, rinse out cup. Then you would flush the feeding tube."

During interview on 12/17/15, at 2:07 p.m. the interim director of nursing stated, "I would expect the nurses to prepare the medications, go into the room and explain what they are doing to the resident, Check placement and check residuals, if ok, separate the plunger from the syringe, flush the tube and then pour each individual medication

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F 322	Continued From page 38 into the syringe flushing between meds. When done flush the tube, remove gloves and wash hands. You can mix all the meds if you have a doctor's order." Enteral Tubes procedure dated July 2015 instructed staff to: "10. Verify tube placement. a. install 10-20 mL [milliliters] of air into the tube while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope to validate air movement in the stomach and b. Aspirate 2-10 mL of gastric contents and reinstall." "13. Remove plunger from syringe, attach syringe to tube pour medication(s) into syringe, and allow to flow by gravity."	F 322		
F 323 SS=E	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 review, the facility failed to ensure supervision for smoking materials was provided for 9 of 16 residents (R167, R43, R31, R41, R72, R68, R8, R168, R135). In addition, the facility failed to ensure a stand lift was properly used for 1 of 1	F 323	F 323 Smoking: On 12/22/2015 the smoking safety data collection and assessment was completed for R167 and resident's status has improved and R167 is now assessed as	1/26/16

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F 323	Continued From page 39 residents (R13) who was observed for transfers. Findings include: During the evening of 12/14, and the days of 12/15, 12/16, and 12/17/15, of the survey, observations were made of the smoking structure (three sided tent) in the parking lot on the Grimes Ave entrance. There were burn marks in three of three wooden benches in the smoking area, and cigarette butts strewn on the ground from the front door to the smoking structure. Cigarette butts were observed in the garbage can, next to the smoking receptacle. The facility smoking policy directed smokers assessed as independent would keep their smoking materials in a locked drawer in their room. Smokers assessed as dependent would have smoking materials secured in the medication rooms. R167 was identified by the facility as a smoker, and was admitted to the facility on 12/10/15, with diagnosis of right lung cancer with metastatic (spread) to brain with mass affect (the cancer tumor is pressing the brain to the side, causing increased pressure in the brain). The care plan dated 12/10/15, indicated family would provide smoking materials and assist with smoking secondary to weakness. The Smoking Safety Data Collection and Assessment dated 12/14/15, indicated R167 could not light his cigarette independently if it was windy, due to use of only one hand. R167 was not able to let go of cigarette and then retrieve it due to weakness. R167 was assessed as a dependent smoking and would smoke with family, who visited daily.	F 323	an independent smoker. R167's family and the POC were updated. On 12/22/2015 the smoking policy and procedure was reviewed with R167. On 12/29/2015 the smoking policy and procedure was reviewed with R43 and guardian and the POC was updated. On 12/24/2015 the smoking policy and procedure was reviewed with R31, R41, R72, and R68. On 12/24/2015 the smoking policy and procedure was reviewed with R118. Note the resident is identified as R8 on the statement of deficiencies, but upon review this is a typo and should read "R118" as there is no R8 on the listing provided by the survey team member. R168 was discharged; however, a smoking safety data collection and assessment was completed as well as a review of the smoking policy and procedure prior to discharge. R135 was discharged. A facility wide audit was completed on 12/17/2015 and fifteen residents have the potential to be affected by this practice. Lock boxes and/or bedside tables with locking drawers were provided for all identified resdients on 12/31/2015. All staff will be in-serviced by 1/26/2016 on smoking policy and procedure as well as interventions in place for identified residents. Audits will be completed by the Director of Social Services and/or designee that will monitor random identified residents five	

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F 323	Continued From page 40 On 12/15/15, at 1:55 p.m. R167 stated he kept his cigarettes and lighter in his coat pocket for easy retrieval. R167 stated he only smoked with his family outside, he just liked to keep the cigarettes and lighter in his pocket, even though he knew they should be kept at the nursing station. On 12/15/15, the fire marshal surveyed the facility and also identified the issues with the smoking area, and directed the facility to reassess all residents for safe smoking. On 12/16/15, at 9:55 a.m. licensed practical nurse (LPN)-C stated R167's cigarettes were secured in the 4th floor medication room. The cigarettes were observed in the medication room. On 12/16/15, at 10:00 a.m. R167 stated the social worker came and took his cigarettes last night. With permission the jacket pocket was checked, the cigarettes and lighter were no longer in the pocket. R43's quarterly Minimum Data Set (MDS) dated 9/11/15, indicated R43 had severely impaired cognition. Elopement plan of care dated 9/11/15, indicated resident had dementia and was on a smoking program and always returned to the floor/unit/room after going out to smoke. R43's diagnoses included dementia, major depressive disorder, alcohol use and encephalopathy obtained from the admission record dated 10/13/15. The Smoking Safety Data Collection and Assessment dated 12/09/15, indicated R43 an	F 323	times a week for one week, then three times a week for one week, and weekly thereafter. Audits will aslo include that cigarettes are being properly disposed of. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs. Safe transfers: On 12/28/2015 Director of Rehabilitation (DOR) completed a clincial review to assist in modifications to R13's POC as it relates to transfers and toilet use. R13's POC was updated. A facility wide audit was completed on 12/17/2015 and twenty residents have the potential to be affected by this practice for which staff use the mechanical lift. In-servicing will be provided to nursing staff by 1/26/2016 that addresses standards of practice as it relates to safe transfer techniques. Audits will be completed by the DON and/or designee that will monitor identified residents requiring transfer assist, including those residents who require the use of a mechanical lift, three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance(QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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independent smoker, however the assessment did not indicated storage of the cigarettes, and lighters had been reviewed to ensure R43 understood where to store them per the facility policy.

On 12/15/15, at 9:11 a.m. during a tour to the smoking area located to the left side of the entrance door surveyors observed a concert garbage with the inside made of hard plastic stationed outside the tent. The can was lined with a clear plastic bag and trash with multiple cigarette butts were observed disposed in the can. Right next to garbage can was a black cigarette receptacle that was observed to be filled and cigarette butts were seated on the receptacle hole. Also noticed were several cigarettes butts in the area on the floor all the way to the entrance past the yellow line and the benches located inside the smoking tent were observed with burn marks along the sitting part. At the time of observation two residents in the area smoking which included R43. At 9:14 a.m. R43 was observed dispose the cigarette butt in the receptacle by the garbage that was filled and left the area after putting the lighter in her jacket and went into the building. During observation R43's clothing checked no burns holes noted.

On 12/16/15, at 3:45 p.m. observed several residents inside the tent smoking at the time. The smoke receptacle stationed by the garbage can observed to be full and some cigarette butts observed inside the garbage can at the time.

On 12/17/15, at 10:37 a.m. during the environment tour under R43's wheelchair cushion was observed two cigarettes and a lighter stored when staff brought the wheelchair out of the room

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to be reviewed. During the tour the executive director and several other management staff were present.

On 12/15/15, at 1:09 p.m. housekeeping aide (HKA)-A stated "I actually do not see that many the smokers go out as they go when they want and has not seen them stored" when asked what she could do if she saw the cigarettes stored all around the room. HKA further stated if she would find cigarettes for a resident who left them lying around the room she would bring them to the nurse to make sure the resident was supposed to have the cigarettes.
-At 1:12 p.m. the floor care tech stated she saw some residents store cigarettes in the bedside tables and night stands, "I have seen a lighter out in the room and this person I believe he can have it and goes out to smoke. I know another resident in the third floor she is on a program and would ask." When asked if she would take the cigarettes and lighter to the nurse if she saw them not stored properly floor care tech stated "On the residents who I know go out to smoke I would not take it out of the room. Some residents have their families bring smokes. Some residents would be begging for smokes and we have been told not to give them." When HKA-A and floor care tech were both asked if they knew the facility smoking policy both stated for those residents who are okay to go out smoke were able to keep all their supply in their possession and for those who were in the program would have their cigarettes stored in the medication room. When asked if either of them knew the facility smoking policy both stated they were not sure at this time and would get back to surveyor. When asked specifically about smoking supplies being locked both stated they were neither sure and would be getting back to

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surveyor about it. Both indicated residents were not supposed to smoke with oxygen and would have the tank at the front of the building and would not get it after they are done smoking.

On 12/15/15, at 1:31 p.m. the executive director (ED) stated she had not seen any resident out smoke with oxygen. ED stated she had worked at the facility for five years and had not had anyone out smoking with oxygen. When asked about the smoking policy ED stated was done on general orientation. ED stated "We have not had anyone flag as not being safe. Social service completes the assessment and some of the unit managers would help and in the past some residents have had to swap cigarettes with their oxygen tank. In the past they have left the tank at the front and had been very reliable." When asked if she would expect all the staff to know the smoking policy ED stated she would not expect as this was more clinical and thought the staff should be able to notice the safety but would not be able to know the answers exactly to the policy. When asked about storage of cigarettes and other supplies ED stated if residents had on their possession would be safe like in their pockets as they had been assessed to be safe to smoke and handle the supplies. ED also stated if a resident would take cigarettes and other supplies and left them on the bed it would flag for the resident to be re-assessed. When asked about checks/audits were done to make sure residents followed through with the policy ED stated she did do audits and would check and if she had noticed any concerns would address it immediately. ED further stated she had not seen any concerns during her audits and thought the facility had one of the best smoking programs.

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F 323	Continued From page 44 On 12/16/15, at 7:39 a.m. both the floor care tech and HKA-A approached and stated residents would be able to keep the cigarettes on them and also have them stored in the cabinets in their rooms which they had a key to. R31's Mood and behavior symptom assessment/plan of care rewritten 5/8/15, indicated resident smoking in-between door on first floor. Interventions included offer to get jacket and remind of risks and consequences of not wearing a jacket. Re-direct and remind of rules and consequences. The Care Area Assessment (CAA) dated 5/18/15, indicated cognitive impairment. CAA dated 5/15/15, indicated poor memory. The Fall injury assessment: prevention and management plan of care dated 5/15, plan entry dated 12/15/15, indicated resident found to have lighter fluid in his room, goal was to comply with smoking policy and intervention was to remind him of the smoking policy. Maintenance will hold onto can for resident and when he wants to refill request assist. R31's smoking safety data collection and assessments dated 11/6/15, indicated R31 was an independent smoker. Non-compliance with smoking policy was checked along with address goals and interventions on the plan of care. Smoking assessment dated 8/27/15, 5/8/15, and 2/6/15, indicated resident was an independent smoker and the assessment would be addressed on the plan of care were checked. The quarterly MDS dated 11/6/15, indicated moderate cognitive impairment and diagnoses	F 323		

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F 323	Continued From page 45 included hypertension and peripheral vascular disease. The comprehensive care plan review summary dated 11/18/15, indicated R31 was a smoker, smoking safety dated collection and assessment reviewed and updated and care plan reviewed and updated. On 12/15/15, at 11:49 a.m. R31 not in room, no cigarettes observed in room. At 11:57 a.m. observed R31 in his wheelchair going down the hall toward his room. R31 stated he did smoke and had a pack of cigarettes in his wheelchair. R31 indicated he rolled his own cigarettes and had done that for two years now. He stated shoppers get materials for him and that he received some today. In the room next to his, which was used as a library, observed on the table was a rolling machine, tobacco, approximately four lighters in a drawer, and a BiC lighter that he kept with him. He also had a Zippo lighter fluid bottle on the shelf above the table, which stated flammable on the outside. R31 stated the Zippo should be tossed. R31 also had 10 rolled cigarettes in a box on the table. R31 stated other residents do not wander in the room, they ask permission to come into his library. On 12/15/15, at 12:09 p.m. registered nurse (RN)-A stated he was not aware of the Zippo lighter fluid. R31 stated it should be tossed and RN-A stated it would be tossed. At 12:17 p.m. RN-A stated it was disposed of properly. At 12:57 p.m. RN-A stated he gave it to the maintenance director, indicated they had a locked place in their shop to lock flammables.	F 323		

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F 323	Continued From page 46 R41's Fall/injury assessment: prevention and management plan of care dated 5/14 indicated R41 rolled her own cigarettes occasionally. R41's smoking safety data collection and assessments dated 1/6/15, 4/17/15, and 10/5/15 indicated R41 was an independent smoker and address goals and interventions on the plan of care were checked. On the 7/10/15, assessment it was written in "reviewed 10/6/15-no changes-signed by [RN-A]." The quarterly MDS dated 10/5/15, indicated R41 was cognitively intact and diagnoses included anemia and hypertension. The Comprehensive care plan review summary dated 10/9/15, indicated R41 was smoker, smoking safety data collection and assessment reviewed and updated and care plan reviewed and updated. On 12/15/15, at 11:51 a.m. R41 was lying in bed in her room and stated she was not feeling well today. R41 opened her bedside dresser's second drawer and showed me a pack of 18 cigarettes. R41 had two packs of cigarettes in the top locked drawer and half (½) carton in the bottom drawer. R41 stated she kept a lighter in her jacket and smoked outside. R72's mood and behavior symptom assessment care plan dated rewritten 10/3/14, entry dated 8/14, indicated R72 started to roll his own cigarettes. R72's smoking safety data collection and	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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assessments dated 2/14/15, 5/15/15, 8/12/15, and 11/12/15 indicated resident was an independent smoker and address goals and interventions on the plan of care were checked.

R72's Fall/injury assessment: prevention and management plan of care dated 8/12/15, indicated R72 was independent with smoking.

The CAA dated 8/18/15, indicated R72 had cognitive impairment.

The quarterly MDS dated 11/12/15, indicated R72 was cognitively intact and diagnoses included anemia, hypertension, cerebrovascular accident and dementia.

The comprehensive care plan review summary dated 11/25/15, indicated R72 was a smoker.

On 12/15/15, at 11:44 a.m. observed resident's room to have six empty cigarette packages on top of the refrigerator and three empty packages on top of the dresser table eight individual cigarettes were observed on the bedside table, 10 cigarettes were in a pack in his hat, along with a lighter on the bedside table. R72 stated he was able to smoke outside anytime and stated he had no cigarettes in his bedside drawer.

R68
On 12/15/15, at 12:19 p.m. R68 stated she rarely smoked and kept a partial cigarette pack and lighter in her camp hero jacket. R68 stated she smoked about two to three cigarettes a day.

R68's 11/25/15, smoking safety data collection and assessment indicated independent smoker

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F 323	Continued From page 48 "resident signs in & out at desk" and address goals and interventions on the plan of care was checked. The quarterly MDS dated 11/25/15, indicated R68 was cognitively intact and diagnoses included cerebrovascular accident. R8 On 12/15/15, at 11:56 a.m. R8 was not in his room but was observed a pack of 10 cigarettes and lighter sitting on top on a boom box resting on sink counter. R8 was in the dining room and stated that he kept cigarettes in a drawer in his room. R8's smoking safety data collection and assessment dated 11/11/15, indicated R8 was an independent smoker. The quarterly MDS dated indicated 11/11/15, indicated R8 had moderate cognitive impairment and diagnoses included hypertension and dementia. R168 On 12/15/15, at 12:25 p.m. R168 was in the dining room, stated he had a half pack of cigarettes and lighter in his jacket but did not have any extra cigarettes. R168's smoking safety data collection and assessment dated 12/10/15, indicated R168 was an independent smoker and address goals and interventions on the plan of care was checked. The Fall/injury assessment: prevention and	F 323		

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management care plan dated 12/9/15, indicated fall/injury risk related to smoking.

The undated comprehensive care plan review summary for R168 indicated smoker.

On 12/15/15, at 12:59 p.m. nursing assistant (NA)-A stated if she saw smoking materials she would report it to the nurse and charge nurse. There was no smoking allowed in the building, residents have to smoke in the area outside.

On 12/15/15, at 1:01 p.m. LPN-A stated sometimes she saw materials in certain rooms, usually a lighter, roll paper and bags of tobacco. If they were not harming anything she would let it be. If the resident was at risk she would involve social services. Social services divided cigarettes and handed them out in the morning. Social services supplies cigarettes to residents and they are purchased with resident's money. A resident must go outside past the door, past the line to the smoke shack. Some people have had certain smoking times in the past, they would keep a lighter at the desk, would go downstairs with a resident, light their cigarettes, watched them smoke and brought them back upstairs.

On 12/15/15, at 1:11 p.m. NA-B stated if she saw smoking materials in rooms she would take it to the nurse's station. NA-B stated she was not aware of the smoking policy.

On 12/15/15, at 1:14 p.m. RN-A stated he did not know what he would do if he saw smoking materials out and about. It is their home if they want to leave smoking materials on their table. They do not have problems with other people going into rooms and stated he did not have

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concerns with cigarette stealers. If they did have a concern he would suggest the cigarettes were locked up. RN-A stated he had not read the smoking policy thoroughly. If a resident was a dependent smoker, the cigarettes and lighter were locked up, meaning they could not smoke on their own. They did have one resident who they locked and distribute her cigarettes. She had six cigarettes kept on the medication cart to avoid all her money being spent on cigarettes. RN-A stated everyone else was an independent smoker. He indicated he would refer to the smoking policy to read it. RN-A stated he was not aware of who was in charge of the policy or how they were ensuring it.

R135 was admitted to the facility on 7/23/15, and was identified by the facility as a smoker on the Nursing Comprehensive Admission Data Collection an Assessment dated 7/23/15. Nursing Comprehensive Admission Data Collection an Assessment indicated, "Complete Smoking Safety Data Collection and Assessment, if yes (or according to state-specific policy)."

R135's admission MDS dated 7/30/15, indicated R135 was cognitively intact and required assistance with activities of daily living (ADLs). R135's admission MDS indicated R135 had diagnoses of a stroke, hemiplegia (paralysis on non-dominate side), seizures, asthma, history of cocaine abuse, intracranial hemorrhage (bleeding in the brain),

The Progress Note dated 7/30/15, indicated R135 was found smoking in his room. Progress Note dated 7/31/15, indicated a care conference was held and social service reviewed the smoking policy and procedure. R135 would go with family

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F 323	Continued From page 51 to smoke. The Smoking Safety Data Collection and Assessment dated 7/30/15, indicated R135 was assessed as an independent smoker. R135's Fall/Injury Assessment: Prevention and Management Care Plan undated page 4 indicated "Assessment Fall/Injury risk related to: Smoking I (independent) Goal Will demonstrate safe smoking daily Intervention Monitor compliance to smoking policy." R135's Fall/Injury Assessment: Prevention and Management Care Plan undated page 4 indicated "Assessment Fall/Injury risk related to: Smoking I (independent) Goal Will demonstrate safe smoking daily Intervention Monitor compliance to smoking policy." R135's Social Service Short Stay Plan of Care page 2 dated 7/30/15, indicated "[R135] was smoking in his room. Intervention instructed staff, "Resident's cigarettes & [and] lighter to be kept at nurses station. Staff will not take resident to smoke, but family members can do so." On 12/15/15, at 1:05 p.m. when asked are you aware of the smoking policy? LPN-D answered yes a resident can not smoke in their bathroom or room. On 12/15/15, at 1:10 p.m. when asked how the facility enforces the smoking policy? RN-B stated we ensure the residents remain safe. If not we have to intervene to allow them to smoke. We will have a family member go out and smoke with them if the resident needs to be supervised.	F 323		

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F 323	Continued From page 52 During interview on 12/17/15, at 2:07 p.m. when the interim director of nurses (IDON) was asked about R135 smoking in room in July, IDON stated there would have been an incident report. Requested IDON locate it and provide to surveyor as it was not provided when requested earlier. Also requested copy of smoking assessment and progress notes for 7/23 through 7/301/15. The director of nursing (DON) stated social service does the smoking assessments. When should a resident who is identified to smoke upon admission have a smoking assessment completed DON stated, "talk to [social worker (SW)-A], she will know what the policy is." During interview on 12/17/15, at 3:45 p.m. SW-A said if residents want to smoke I do the assessment on the day of admission or the next day, otherwise I hold off until they want to smoke. They (resident) may say they smoke but have not smoked since they have been in the hospital. I talk to the resident upon admission about the smoking protocol and let them know there are regulations. I was off on 7/23/15, and 7/24/15. If a transitional care unit resident admits the social worker will talk to the resident. Residents can not smoke in their room MN (Minnesota) Smoking policy revised January 2014, directed: "1. All residents who smoke will be evaluated upon admission, quarterly, and with a significant change of condition, to determine any special smoking needs and to assess their ability to smoke independently. 2. Results of the smoking evaluation will be discussed with the resident/responsible party and addressed in the resident's care Plan. 3. All residents who smoke may only smoke in a	F 323		

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F 323	Continued From page 53 designated smoking area... 9. Residents who are assessed as "Independent smokers may retain possession of their smoking material per the care plan. In such circumstances a locked storage cabinet will be provided. Such residents must adhere to the following requirements: · Combustible items other than smoking materials will not be stored in the locked cabinet · Storage cabinet will be locked at all times with the key in the possession of the resident · No smoking materials will be stored for or given to another resident..." The facility did not follow the policy as the residents had kept either or both smoking materials on their possession. Safe transfers: R13 was observed on 12/16/15, at 7:38 a.m. for morning cares. The cares were completed NA-C. R13 indicated she had to use the bathroom. R13 was assisted to the edge of the bed by two NA assist. When the NA-C went to put the safety belt around R13 the belt would not fit as it was too "tight." The belt was adjusted and again it would not fit. The Velcro safety straps were not used to transfer R13 to the toilet. NA-C assisted the stand into the correct position over the toilet and then R13 was lowered to sit on the toilet. After the toilet use R13 was placed in the wheelchair (w/c) by having staff tilt the w/c backwards to accommodate the legs of the stand as the stand legs could not spread as wide as the w/c width. R13 was admitted to the facility 5/31/14, with admission diagnoses of stroke with hemiplegia (loss of use of one side of the body) dysphagia (difficulty swallowing food and liquids) and	F 323		

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apraxia of speech (difficulty with expressing thoughts).

The annual CAA dated 3/6/15, indicated R13 was unable to participate in cares due to body habitus and refusals of care. R13 required assist of two staff and a stand assist lift to toilet, was usually incontinent and noncompliant with toileting schedule.

The care plan dated 3/9/15, indicated assist of two staff with "EZ stand" [Stand Up Patient Lift] for bed/chair/toilet.

The quarterly MDS dated 11/13/15, indicated R13 was cognitively intact, moderately depressed and required extensive assist of two staff with mechanical stand lift for transfer and toilet use. R13 also had no falls in the past tree months.

On 12/17/15, at 7:13 a.m. RN-B stated, the staff have to lift the w/c to get R13 far enough back, because the legs on the stand would not spread far enough to get over R13's w/c. RN-B "That's what we figured out to get her far enough back in the w/c."

On 12/17/15, at 7:33, NA-C stated "it's been a while since they have been lifting the chair to get her back far enough in the chair that she was comfortable."

On 12/17/15, at 2:05 p.m. RN-C was interviewed and indicated the staff did not follow proper policy and they should have gotten a physical therapy (PT) lift assessment. At 3:48 p.m. RN-C stated R13 "had not had a PT assessment since September 2014, so that assessment would not be accurate for the current time period."

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F 323	Continued From page 55 The manufacturers manual for the Stand Up Patient Lift dated 2010 directed staff "if any attachments are not properly in place, lower the patient back onto the stationary surface and correct this problem - otherwise, injury or damage may occur." Staff were to also detect wear and damage to all parts e.g. "slings, lifting arm and any pivot for slings for signs of cracking, fraying, deformation or deterioration. Replace any defective parts IMMEDIATELY and ensure that the lift is not used until repairs are made."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		1/26/16

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F 329	Continued From page 56 This REQUIREMENT is not met as evidenced by: Based on interview and document review, facility did not ensure adverse side effect monitoring was being completed for 1 of 5 residents (R68) reviewed for unnecessary medications. Findings include: R68's Care Area Assessment dated 4/24/15, indicated R68 received antipsychotic medications. The facility's consultant pharmacy report entitled, Consultation Report Omnicare of Minnesota dated 5/12/15, included: "receives an antipsychotic, and is reported to have fallen or be at high risk for falls... Please consider monitoring postural blood pressures (BP) at least monthly/assessing for orthostatic hypotension per facility policy (or as advised by prescriber)." The medical record lacked any evidence of this irregularity having been brought forward to the facility's attention again even though no orthostatic blood pressures for R68 had been completed since May of 2015. The Medication Administration Record (MAR) included an order dated 5/13/15, for orthostatic blood pressures to be completed monthly, if utilizing an antipsychotic. R68's MAR for May 2015 indicated monitoring of orthostatic blood pressures had not been completed. In addition, the medical record, which included the MAR and Treatment Administration Record, lacked evidence of any orthostatic blood pressures	F 329	F 329 Medication monitoring including postural blood pressures, (e.g. orthostatic blood pressures) for R68 was put into place on 12/28/2015. All residents have the potential to be affected by this same practice; however, a facility wide audit was completed on 12/28/2015 and fourteen residents were identified at risk for monitoring needs for postural blood pressure needs. Nursing staff will be in-serviced by 1/26/2016 on policy and procedure for psychoactive medication symptom assessment/care plan needs. Audits will be completed by the DON and/or designee for identified residents to ensure adequate monitoring is in place weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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having been monitored between May and November of 2015.

The facility provided R68's current care plan dated 5/15/15. The care plan lacked any interventions for adverse side effect monitoring for R68's use of Seroquel (an antipsychotic) or Zoloft (an antidepressant). Although there was an opportunity to have selected interventions appropriate for such monitoring, an entire section of the plan remained unchecked including: Repetitive physical movement, balance while sitting, hypotension, dizziness/vertigo, syncope, unsteady gait, fall in past 30 days, fall in past 31-180 days, hip fracture, swallowing problem, weight loss and orthostatic BP.

R68's quarterly Minimum Data Set (MDS) dated 11/27/15, indicated R68 was cognitively intact and had diagnoses including: cerebrovascular accident, traumatic brain injury, anxiety, and depression. R68 was independent with most activities of daily living and required supervision, and set up help only with locomotion off unit. The MDS also indicated R68 had been admitted to the facility on 4/16/15.

The signed Physician Orders for December 2015, indicated R68 received Seroquel 25 milligrams (mg) every morning, and 50 mg every evening for mood disorder. Staff were also to monitor for the risk of psychopharmacological medications and if noted staff were to document the information in the medical record and notify the medical doctor. The licensed nurses documented "O" for monitoring for the risk of psychopharmacological medications however, there were no documented orthostatic blood pressures as recommended by the pharmacist to help identify potential adverse

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F 329	Continued From page 58 side effects for the use of Seroquel. On 12/17/15 at 9:39 a.m., registered nurse (RN)-B stated they did not monitor orthostatic blood pressures. On 12/17/15 at 3:23 p.m., the interim director of nursing (IDON) stated she did not see documentation indicating orthostatic blood pressures were being monitored. The IDON confirmed she expected such monitoring to be implemented in accordance with the consultant pharmacist's recommendation. The package insert information for Seroquel from AstraZeneca Pharmaceuticals, last revised 10/29/13, indicated one of the adverse side effects for Seroquel was orthostatic hypotension. The information included; "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose." The facility's policy Psychoactive Medication dated 7/15, directed staff to "Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Care Plan." R68's care plan dated 5/15/15, was void any symptoms to monitor for side effects.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		1/26/16

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F 332	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to prevent medication errors for 2 of 7 Residents (R72, R76) reviewed for medication administration. This resulted in a 7.7% medication error rate. Findings include: Gastrostomy tube (G-Tube) administration: R72's G-Tube medication administration and enteral feeding was observed from 8:34 a.m. until 9:27 a.m. registered nurse (RN)-D was observed to crush the listed medications and place them in a blue plastic cup. The medications were Aspirin (a mild analgesic) 81 milligrams (mg) chewable one tablet, Baclofen (a muscle relaxer) 10 mg one tablet, Wellbutrin (an antidepressant) 75 mg two tablets, Finasteride (treatment of benign prostatic hyperplasia (BPH) 5 mg one tablet Norco (an analgesic) 5 mg-325 mg one tablet, Keppra (used to treat epilepsy) 750 mg one tablet, and Calcium with vitamin D 500 mg-200 units (promote bone growth). RN-D poured 20 milliliters (ml) of omeprazole (used to treat gastroesophageal reflux) into a medication cup as ordered by the December 2015 Physician Orders. RN-D put on gloves and using a 60 cc (cubic centimeter) syringe, drew up 50 cc of water and pushed it into the G-Tube, RN-D drew up another 50 cc of water and pushed it into the G-Tube. RN-D then added 50 cc of water and added it to	F 332	F 332 G-Tube placement: R72's Orders and POC was reviewed on 12/17/2015 as it relates to G-tube placement, medication administration and nutritional formula tube feeding administration. Resident receives bolus feedings, which is tolerated without sign or symptoms of adverse affects, to allow for increased independence rather than have a continuous tube feeding formula administered. RN-D was provided re-education as it relates to bolus tube feedings, g-tube placement verification and G-tube medication administration on 12/28/2015. A facility wide audit was completed on 12/17/2015 and four residents were identified that have the potential to be affected by this practice. In-servicing will be provided to staff by 1/26/2016 that addresses standards of practice as it relates to G-tubes and tube feedings. Audits will be completed by the DON and/or designee that will monitor identified residents requiring G-tube placement checks, medication and tube feeding administrations, three times a week for two weeks, the weekly. Audits will be reviewed durign the qulaity assurance (QA) meeting to determine if any trends are identified, and recommendations	

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F 332	Continued From page 60 the plastic cup containing the medications. Using the 60 cc syringe RN-D drew up the medication and pushed the meds into the G-Tube. RN-D then threw the plastic cup that had contained the medications in the trash with white liquid and lumps in bottom of cup. RN-D then flushed the G-tube with 50 cc of water and drew up 50 cc of Jevity (nutritional supplement) 1.5 with a syringe and pushed it into the G-Tube until 225 cc of Jevity had been given. RN-d flushed the G-tube with 50 cc of water than gave the omeprazole and flushed the G-tube with 50 cc of water. A visible layer of omeprazole remained in the medication cup. R72's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated R72 was cognitively intact and was independent with activities of daily living with the exception of eating. R72's diagnoses listed on the December 2015 Physician Orders included dysphagia, and malignant neoplasm of the mouth. In addition, the orders read, "Ok to crush and give meds together, flush with 60 ML [milliliters] of H2O (water) following meds," "Give all Meds via GT," and "Check for G-tube placement prior to feeding and medication administration. Flush G-tube with 250 ml of water at 12 midnight, 9 AM, 12 PM, 2 PM, 4 PM and 8 PM." At 12/17/15, at 9:27 am RN-D verified there was medication powder and fragments still left in the bottom of the cup that the dissolved pills were in. RN-D verified that the medication cup containing the crushed medications still had medication in it. RN-D also verified the medication cup containing omeprazole still had medication in it. RN-D acknowledged the gastrostomy tube placement	F 332	made for continued audits/monitoring needs. Insulin administration On 12/28/2015 R76's blood sugars were reviewed and results were discussed with the diabetic clinic with no new orders noted. Resident is without any adverse effects noted related to this practice. A facility wide audit was completed on 12/28/2015 and sixteen residents have the potential to be affected. Nursing staff will be in-serviced by 1/26/2016 and will include policies and procedures related to insulin injection, utilization of FlexPens, glucose monitoring and infection control. Audits will be completed by the DON and/or designee that will monitor identified residents requiring insulin injections three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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should have been checked before giving the medication or tube feeding. RN-D stated had never given gastrostomy tube medications or feedings via gravity through a syringe, "that is old practice."

During interview on 12/17/15, at 9:33 a.m. RN-A stated a nurse should check placement and residuals before giving anything by a gastrostomy tube. RN-A verified when a nurse administers medication by a G-tube they would flush the G-tube with water then add water to the crushed medications, take the syringe apart, pour the medication in the syringe. You might have to keep adding water to the cup to make sure you get it all the medication. You would then do liquid medications, rinse out cup. Then you would flush the feeding tube.

During interview on 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) stated, "I would expect the nurses to prepare the medications, go into the room and explain what they are doing to the resident, Check placement and check residuals, if ok, separate the plunger from the syringe, flush the tube and then pour each individual medication into the syringe flushing between meds. When done flush the tube, remove gloves and wash hands. You can mix all the meds if you have a doctor's order."

Enteral Tubes procedure dated July 2015 instructed staff to:
"10. Verify tube placement.
a. install 10-20 ml of air into the tube while simultaneously auscultating over the left upper quadrant of the abdomen with a stethoscope to validate air movement in the stomach
and

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F 332	Continued From page 62 b. Aspirate 2-10 mL of gastric contents and reinstall." "13. Remove plunger from syringe, attach syringe to tube pour medication(s) into syringe, and allow to flow by gravity." R72 did not receive the full dose of medications as ordered by the physician. Insulin administration: R76s Admission Record dated December 2015, indicated R76 had diagnosis of diabetes mellitus. R76's blood sugars between 12/1/15, to 12/16/15, ranged from a low of 115 to a high of 316. The Physicians Order for the period December 2015, directed staff to administer Novolog Flexpen (used to control blood sugar) 100 unit/milliliter sliding scale based three times a day with meals For blood sugar 150-200=4 units, 201-250=8 units 251-300= 12 units 301-350=16 units, 351-400= 20 units, blood sugar greater than 400 =24 units. During medication administration observation on 12/16/15, at 12:18 p.m. licensed practical nurse (LPN)-B verbalized R76's blood sugar was 223 and would need eight units of Novolog. LPN-B attached the needle to the Flexpen and dialed 8 units for administration. LPN-B did not wiped off the stopper of the Novolog Flexpen and did not prime the pen. LPN-B wiped R76's abdomen with alcohol wipe and gripped skin to administer the Novolog. Surveyor stopped the administration and had LPN-B correctly prime the Novolog Flexpen. LPN-B did not wipe off the stopper on the Flexpen prior to attaching the needle. R76's quarterly MDS dated 10/15/15, indicated R76 was cognitively intact. Diagnosis identified on	F 332		

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F 332	Continued From page 63	F 332		

the MDS include diabetes mellitus.

During interview on 12/16/15, at 12:37 p.m. interview LPN-B stated, I have never heard about priming a Flexpen. No one said we had to wipe the top. I thought it was sterile because it had a cap."

During interview on 12/17/15, at 12:21 p.m. RN-B said it would not hurt to wipe the stopper off with alcohol, so yes. RN-B verified you are supposed to prime flex pens before you dial up the medication. RN-B stated I have not had education on Flexpen since I have been here.

During interview on 12/17/15, at 2:07 p.m. the IDON verified the process to give Insulin via a Flexpen: wipe off the end of the pen with alcohol, attach a needle, prime the pen with 2 units of insulin, dial up the dose required, take resident to room, explain process, administer the insulin. The IDON stated not priming the pen would result in the resident not getting the full dose. Not wiping the end of the pen off could result in an infection.

Discharged Resident Medication Transfer Record printed 12/17/15, for NovoLog Flexpen provided as manufacture insert. It instructed residents to "Learn all preparation and usage instructions from your healthcare professional and the product package."

NovoLog Flexpen manufacture guidelines dated April 2015, instruct users to
"Step 1: Prepare your NovoLog Flexpen: Pull of the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from the needle and screw it onto your Flexpen tightly. Step 2: Step 2: Doing the air shot before each

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F 332	Continued From page 64 injection: small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to select 2 units. Hold your Flexpen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. If no drop appears, change the needle and repeat." R76 did not receive the full amount of insulin as ordered by the physician.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 residents (R76) were free of significant medication errors related to insulin administration this had the potential to affect 4 residents who receive insulin by insulin pens. Findings include: R76's Admission Record dated December 2015, indicated R76 had diagnosis of diabetes mellitus. R76's blood sugars between 12/1/15, to 12/16/15, ranged from a low of 115 to a high of 316. The Physicians Order for the period December 2015, directed staff to administer Novolog Flexpen (used to control blood sugar) 100	F 333	F 333 On 12/28/2015 R76's blood sugars were reviewed and results were discussed with the diabetic clinic with no new orders noted. Resident is without any adverse effects noted related to this practice. A facility wide audit was complted on 12/28/2015 and sixteen residents have a potential to be affected. Nurisng staff will be in-serviced by 1/26/2016 and will include policies and procedures related to insulin injections, utilization of FlexPens, glucose monitoring and infection control.	1/26/16

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F 333	Continued From page 65 unit/milliliter sliding scale based three times a day with meals For blood sugar 150-200=4 units, 201-250=8 units 251-300= 12 units 301-350=16 units, 351-400= 20 units, blood sugar greater than 400 =24 units. During medication administration observation on 12/16/15, at 12:18 p.m. licensed practical nurse (LPN)-B verbalized R76's blood sugar was 223 and would need eight units of Novolog. LPN-B attached the needle to the Flexpen and dialed 8 units for administration. LPN-B did not wiped off the stopper of the Novolog Flexpen and did not prime the pen. LPN-B wiped R76's abdomen with alcohol wipe and gripped skin to administer the Novolog. Surveyor stopped the administration and had LPN-B correctly prime the Novolog Flexpen. LPN-B did not wipe off the stopper on the Flexpen prior to attaching the needle. R76's quarterly Minimum Data Set (MDS) dated 10/15/15, indicated R76 was cognitively intact. Diagnosis identified on the MDS include diabetes mellitus. During interview on 12/16/15, at 12:37 p.m. interview LPN-B stated, "I have never heard about priming a Flexpen. No one said we had to wipe the top. I thought it was sterile because it had a cap." During interview on 12/17/15, at 12:21 p.m. registered nurse (RN)-B said it would not hurt to wipe the stopper off with alcohol, "so yes." RN-B verified you are supposed to prime Flexpen's before you dial up the medication. RN-B stated, "I have not had education on Flexpen since I have been here."	F 333	Audits will be completed by the DON and/or designee that will monitor identified residents requiring insulin injections three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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F 333	Continued From page 66 During interview on 12/17/15, at 2:07 p.m. the interim director of nursing (IDON) verified the process to give Insulin via a Flexpen: wipe off the end of the pen with alcohol, attach a needle, prime the pen with 2 units of insulin, dial up the dose required, take resident to room, explain process, administer the insulin. The IDON stated not priming the pen would result in the resident not getting the full dose. Not wiping the end of the pen off could result in an infection. Discharged Resident Medication Transfer Record printed 12/17/15, for NovoLog Flexpen provided as manufacture insert. It instructed residents to "Learn all preparation and usage instructions from your healthcare professional and the product package." NovoLog Flexpen manufacture guidelines dated April 2015, instruct users to "Step 1: Prepare your NovoLog Flexpen: Pull of the pen cap. Wipe the rubber stopper with an alcohol swab. Remove the protective tab from the needle and screw it onto your Flexpen tightly. Step 2: Step 2: Doing the air shot before each injection: small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to select 2 units. Hold your Flexpen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle. If no drop appears, change the needle and repeat."	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		1/26/16

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F 371	Continued From page 67 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe and sanitary condition in the kitchen storage and food preparation areas. In additional, the facility failed to ensure hair restraints were worn. This had the potential to affect 71 of 72 residents in the facility who ate out of the kitchen. Findings include: On 12/16/15, at 2:09 p.m. during kitchen tour with nutrition services manager (NSM), the following was observed: -a ¼ quart full container of white milk and ¾ quart full container of chocolate milk, with no open for use date on them. -¾ full bag of open pasta noodles was observed. Although the facility found a used by date on the package, the package of noodles were left open without closure to prevent contamination of the noodles. During the entire tour through the kitchen, walk-in cooler, and freezer on 12/16/15, at 2:09 p.m. the	F 371	F 371 No residents were found to be affected by this practice; however, this had the potential to affect 71 of 72 residents in the facilty on that day. All residents have the potential to affected by these practices that eat out of the kitchen. In-servicing will be provided to the dietary staff related to food storage and sanitary conditions and review policies and procedures related to infection control by the Nutrition Services Mangaer (NSM) and/or designee by 1/26/2016. Audits will be completed by the NSM and/or designee that will monitor sanitary storage in food prep areas, including wearing of hair nets, the cleaning schedule three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified and recommendations made for	

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F 371	Continued From page 68 NSM was observed to not be wearing a hair restraint to cover his beard. During the tour, NSM was also observed to bend down to lower shelves and lift individual baking pans to inspect them to ensure they were dry. On 12/17/15, at 10:22 a.m. the dirty dish area was observed. There were three empty dishwasher dish trays standing upright on their side on the floor in front of the dishwasher. The dietary aide removed an empty dishwasher tray from the floor, placed it on the dishwasher belt, and loaded it with dirty dishes. She then opened the dishwasher cover and pushed the clean dish tray to the outside by pushing the dirty dish tray onto the clean one. The NSM stated it was not sanitary to be done that way and informed the dietary aide. On 12/17/15, at 10:29 a.m. NSM stated the milk should have dates when opened for use. He stated the pasta noodles should have had a twist tie on the bag and be closed. On 12/17/15, at 10:32 a.m. NSM stated anyone working with food should wear a beard net. He stated if they were not mixing/working with food it was not necessary to wear one. He stated he would wear a net if he was cooking food and serving at the steam table. The 2013 Food and Drug Administration (FDA) Food Code under the section of Hair Restraints read, "(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD;	F 371	continued audits/monitoring needs.	

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F 371	Continued From page 69 clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." The facility sanitation procedures policy dated July 2015, included "3. Wear a hair restraint at all times... Cover all of hair, including facial hair. Beards must be covered."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consultant pharmacist recommendations were acted upon for 1 of 5 residents (R68) reviewed for unnecessary medications. Findings include: R68's Care Area Assessment dated 4/24/15, indicated R68 received antipsychotic medications. The facility's consultant pharmacy report entitled,	F 428	R68's consultant pharmacist recommendations to monitor postural blood pressures at least monthly was obtained and put into place on 12/28/2015. All residents have the potential to be affected by this same practice, however a facility wide audit was completed on 12/18/2015 and fourteen residents were identified at risk for monitoring needs for postural blood pressures. Nursing staff will be in-serviced by	1/26/16

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F 428	Continued From page 70 Consultation Report Omnicare of Minnesota dated 5/12/15, included: "receives an antipsychotic, and is reported to have fallen or be at high risk for falls... Please consider monitoring postural blood pressures (BP) at least monthly/assessing for orthostatic hypotension per facility policy (or as advised by prescriber)." The medical record lacked any evidence of this irregularity having been brought forward to the facility's attention again even though no orthostatic blood pressures for R68 had been completed since May of 2015. The Medication Administration Record (MAR) included an order dated 5/13/15, for orthostatic blood pressures to be completed monthly, if utilizing an antipsychotic. R68's MAR for May 2015 indicated monitoring of orthostatic blood pressures had not been completed. In addition, the medical record, which included the MAR and Treatment Administration Record, lacked evidence of any orthostatic blood pressures having been monitored between May and November of 2015. The facility provided R68's current care plan dated 5/15/15. The care plan lacked any interventions for adverse side effect monitoring for R68's use of Seroquel (an antipsychotic) or Zoloft (an antidepressant). Although there was an opportunity to have selected interventions appropriate for such monitoring, an entire section of the plan remained unchecked including: Repetitive physical movement, balance while sitting, hypotension, dizziness/vertigo, syncope, unsteady gait, fall in past 30 days, fall in past 31-180 days, hip fracture, swallowing problem, weight loss and orthostatic BP.	F 428	1/26/2016 on policy and procedure for psychoactive medication symptom assessment/ care plan needs. Audits will be completed by the DON or designee for identified residents to ensure adequate monitoring is in place weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs.	

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F 428	Continued From page 71	F 428		

R68's quarterly Minimum Data Set (MDS) dated 11/27/15, indicated R68 was cognitively intact and had diagnoses including: cerebrovascular accident, traumatic brain injury, anxiety, and depression. R68 was independent with most activities of daily living and required supervision, and set up help only with locomotion off unit. The MDS also indicated R68 had been admitted to the facility on 4/16/15.

The signed Physician Orders for December 2015, indicated R68 received Seroquel 25 milligrams (mg) every morning, and 50 mg every evening for mood disorder. Staff were also to monitor for the risk of psychopharmacological medications and if noted staff were to document the information in the medical record and notify the medical doctor. The licensed nurses documented "O" for monitoring for the risk of psychopharmacological medications however, there were no documented orthostatic blood pressures as recommended by the pharmacist to help identify potential adverse side effects for the use of Seroquel.

On 12/17/15 at 9:39 a.m., registered nurse (RN)-B stated they did not monitor orthostatic blood pressures.

On 12/17/15 at 2:31 p.m., the consultant pharmacist stated she expected orthostatic blood pressures to be monitored at least monthly.

On 12/17/15 at 3:23 p.m., the interim director of nursing (IDON) stated she did not see documentation indicating orthostatic blood pressures were being monitored. The IDON confirmed she expected such monitoring to be implemented in accordance with the consultant pharmacist's recommendation.

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F 428	Continued From page 72 The package insert information for Seroquel from AstraZeneca Pharmaceuticals, last revised 10/29/13, indicated one of the adverse side effects for Seroquel was orthostatic hypotension. The information included; "Patients should be advised of the risk of orthostatic hypotension (symptoms include feeling dizzy or lightheaded upon standing, which may lead to falls), especially during the period of initial dose titration, and also at times of re-initiating treatment or increases in dose." The facility's policy Psychoactive Medication dated 7/15, directed staff to "Monitor regularly for side effects as indicated on the Psychoactive Medication Symptom Assessment/Care Plan." R68's care plan dated 5/15/15, was void any symptoms to monitor for side effects.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		1/26/16

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F 431	Continued From page 73 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not ensure expired medications/treatments were discarded in 3 of 3 medications rooms; the facility did not ensure outgoing (medications to be sent back to pharmacy or destroyed in 1 of 3 medication rooms. This had the potential to affect all 73 residents. The facility failed to ensure the medication storage refrigerator was cleaned and defrosted in 1 of 3 medication rooms. In addition, the facility did not ensure Fentanyl (narcotic) patches were accurately destroyed to prevent potential diversion for 2 of 3 residents (R29, R10). Also, the facility failed to ensure medication carts were locked for 1 of 6 medications carts that were observed. Findings include:	F 431	The expired medications identified in the 3 medication rooms were discarded and medications requiring to be sent back to the pharmacy or destroyed was completed on 12/17/2015. The medication storage refrigerator located in the second floor medication room was cleaned and defrosted on 12/17/2015. A facility wide audit was completed on 12/18/2015 to ensure medication carts were locked and Fentanyl patches were accurately destroyed to prevent potential diversion, no additional findings were noted. All residents have the potential to be affected. Nursing staff will be in - serviced by	

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F 431	Continued From page 74 Second floor medication room On 12/17/15, at 1:36 p.m. the medication room storage tour was completed with registered nurse (RN)-A who provided access to the medication room. Upon opening, the second cabinet the shelves were observed overflowing with multiple bottles, pill cards of various medications and treatments. A tote with multiple medications was observed stored under the sink, which appeared to have dry water stain and water damage. Some of medications were observed to either have brown drips on the cap or side unsure what the substance was. In addition, the following were observed: - 15 bottles of Iodoform (antiseptic wound packing stripes) stored inside the sink in the medication room of which some were in a box and four loosely lying inside the sink that had dried white soap scum all over the sink. RN-A verified and stated, "They is a better place to be store them. We do have a supply room." - Three Zinc 50 milligram (mg) high potency 100 tablets bottles with expiration 10/15. - Engerix B (hepatitis B medication) vials, eye drops and with acetaminophen suppositories stored together in a small tote. - one infusion ball device for Mycamine 100 mg (an antibiotic) stored in the refrigerator crisper drawer with a discard date after "12/11/15." On 12/17/15, at 1:52 p.m. RN-A verified the expired medications stated they were not supposed to be stored in the refrigerator. RN-A acknowledged and stated, "There is a lot of work that needs to be done." When asked how often medications were destroyed or sent back to the pharmacy to be disposed RN-A stated the last time it had been done was three months ago. When asked who was responsible for making	F 431	1/26/2016 on the policies and procedures related to receipt and disposition of all controlled drugs, the storage of drugs, the process to discard expired drugs, drugs requiring to be returned to the pharmacy, and the monitoring and care related to the medication refrigerators including the cleaning and defrosting process. Audits will be completed by the DON or designee for all of the medication rooms, medication and treatments carts to ensure adequate monitoring is in place three times per week for one week. then weekly. In addition controlled drug audits will be completed to ensure Fentanyl patches were accurately destroyed to prevent potential diversion three times weekly for one week, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs.	

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F 431	Continued From page 75 sure expired medications were not stored in the medication room RN-A stated "The final responsibility is mine." When asked if medications were supposed to be stored together with suppositories RN stated they should have been stored separately. 2ND FLOOR REFRIGERATOR FREEZER On 12/17/15, at 1:54 p.m. during medication storage tour with RN-A the freezer was observed to have a two-three inch thick build up frost. Three ice packs were observed encased in the frost. In addition, the thick frost was observed to have an orange discoloration. RN-A stated the nurses on night shift were supposed to be cleaning and defrost the refrigerator and freezer once a month. Fentanyl patches disposal Second Floor: On 12/17/15, at 2:07 p.m. a tour of the medication cart was completed with RN-A. During the tour inside the narcotic box was observed an opened box of Fentanyl patches for R29. When asked what the facility policy was for disposing used patches RN-A stated two nurses had to witness the destruction and both nurses were supposed to sign off on the Medication Administration Record (MAR). During review of R29's MAR and narcotic book, from 12/1/15 to 12/16/15, it was revealed R29 had received the Fentanyl patch five times, of which only three times two nurses had documented witnessing the destruction. Third Floor On 12/17/15, at 2:30 p.m. RN-F provided access	F 431		

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F 431	Continued From page 76 to the medication cart and the narcotic box. During the tour, three Fentanyl patches for R10 were observed stored inside the narcotic box. When asked what the facility policy was for destroying the used patches, RN-F stated two nurse were supposed to witness the destruction. RN-F verified R10 had the patch removed and destroyed six times from 12/1/15, to 12/16/15, of which four times did not have a second nurse sign off witnessing the destruction and one time no nurse had signed off on the MAR the destruction on 12/16/15. Third Floor medication room On 12/17/15, at 3:45 p.m. during a subsequent medication tour to the medication room with RN-F who provided access the following were observed: -Hemoccult (a test to look for blood in stool) test kit with expiration 5/2015, and three boxes of Anticoat absorbent wound dressings with expiration 1/2014, and other two 12/2013, all stored in a shelve in the medication room. In addition, the biohazard refrigerator was observed with two inches buildup frost. RN-F verified stated would be cleaned. When asked who was responsible for making sure the medication room was free of expired medications and treatments stated was the nurse manager and the other managers would help. Also on the second shelves of the refrigerator was observed Glycerin suppositories (bowel stimulant)stored together with insulin flex pens, and eye drops. When asked about medication storage RN-F stated was the policy to separate the medications. On 12/17/15, at 2:57 p.m. the interim director of nursing (IDON) stated expired medications were	F 431		

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F 431	Continued From page 77	F 431		

supposed to be pulled from cart and medication room for destruction and suppositories were supposed to be stored separately from other medications. IDON further stated the nurses were supposed to follow the policy of two nurse sign when the patches are removed and destruction and the nurses were supposed to follow the policy for cleaning the refrigerators.

Medications were not properly stored on one medication cart and two medication carts were not properly secured.

Improperly stored medication:
The medication cart was observed on 12/16/15, at 9:55 a.m. with RN-B. RN-B checked the 3rd floor treatment cart with RN-B and director of nursing (DON). Both nurses acknowledged the Santyl wound product was not separated from the oral medication. RN-B Stated, "You are right, the Santyl was not placed in bag " as it was the only wound tube product in the drawer. The drawer contained two empty bags which with two different resident names. When asked what the risk was of using the same tube on two different residents RN-B replied, "If not handled right you might take something from one resident to another resident."

A bottle of eye drops Voltaren (used for glaucoma) 1 % was dated as open on 2/17/14. RN-B stated [R87] was not receiving this treatment. RN-B stated if a medication or treatment is discontinued the nurses are to remove the ointment from cart.

Unlocked medication carts:
On 12/16/15, at 11:53 a.m. licensed practical nurse (LPN)-B was observed to walk down to the

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F 431	Continued From page 78 nurses desk leaving the medication cart unlocked. - At 11:56 a.m. LPN-B returned and locked cart. No resident, staff or visitor had approached the cart. - At 12:05 p.m. the medication cart was left unlocked as LPN-B walked into resident room to perform a blood sugar test. LPN-B closed the door to R76's room. The medication cart was out of sight. - At 12:08 p.m. the LPN-B returned to the cart. No resident, staff or visitor had approached the cart while it remained unlocked. - At 12:10 p.m. through 12:13 p.m. LPN-B left medication cart unlocked on South hall way and went to help a resident wheel down the hall. No resident, staff or visitor had approached the cart while it remained unlocked. - At 12:26 p.m. LPN-B left R76's insulin pen with needle intact, on top of the medication cart while in dining room. The medication cart was not in nurse's reach or view. - At 12:37 p.m. LPN-B was interviewed and said, "I should not have left it there. I got rattled and yes, I forgot to lock the cart when I went down to see if R76 was around. I am not supposed to leave the cart unlocked. It is not how I normally do things." The medication cart contained various insulin product." On 12/17/15, at 12:21 p.m. RN-B stated, "Carts should be locked when the nurse is not with them. Insulin pens should not be left on top of med cart if nurse is not at the medication cart." During interview on 12/17/15 at 2:07 p.m. IDON stated, "Med carts should be locked when the nurse is not there. There is risk for injury if they [residents] get in the cart."	F 431		

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F 431	Continued From page 79 Destruction of Controlled Drugs effective July 2015, directed: "2. Destroy used transdermal patches, (e.g. Fentanyl), following removal from the resident. a. Two licensed nurses must sign for the destruction of the used patch on the resident's Medication Administration Record ..." Storage and Expiration of Medications, Biologicals, Syringes and Needles policy revised 1/1/13, directed: "3. General Storage Procedures: 3.2. Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biological. 3.4. The facility should ensure that infusion therapy products and supplies are stored separately from other medications and biologicals, under appropriate temperature and sterility conditions, according to the manufacturer's or supplier's recommendations. 16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biological in accordance with pharmacy return/destruction guidelines and other Applicable Law,..."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		1/26/16

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F 441	Continued From page 80 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow infection control precautions for 8 of 8 residents (R13, R76, R1, R132, R75, R31, R61, R14) reviewed for infection control. Findings include:	F 441	Diabetic care: R13, R 76, R1, R132, R75, R31, R61, R14 clinical records were reviewed on 1/5/2016 for infection control purposes to ensure each resident was without infections at the time this practice was observed. No infections were noted. LPN-D, RN -G and RN-A verbalized	

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F 441	Continued From page 81 Diabetic care: R13: On 12/14/14, at 6:04 p.m. licensed practical nurse (LPN)-D was observed come out of R13's room wearing a pair of gloves and had a glucometer in her hand. LPN-D disposed the lancet then grabbed the tip of the used stripe with blood disposed it in the sharps container, then took a SANI-PDI wipe (germicidal disposable wipes) that was on top of the treatment cart wiped the glucometer briefly wrapped it with wipe set the glucometer inside on the top drawer of cart. LPN-D then still wearing the same gloves picked a pen and documented in the treatment sheets. LPN-D then pulled the drawer with same gloves obtained an insulin vial draw insulin went to R13's room pulled the privacy curtain was overheard indicate to R13 she was going to give her insulin. LPN-D then came out of room with same gloves disposed the syringe then went into R13's wheeled resident out of room to the hallway then proceeded to wheel the cart down the hallway from last room in the south hallway to the last room in the north hallway still with same gloves on. The quarterly Minimum Data Set (MDS) dated 11/13/15, indicated R13 was a diabetic and had no infections. R76: On 12/14/14, at 6:10 p.m. LPN-D was observed look inside R76's room removed the gloves re-applied another pair without washing hands or using hand sanitizer went into R76's room set the glucometer on the bedside pull table without a barrier punctured the second finger obtained a drop of blood set the glucometer on the table	F 441	correct infection control practice after 1:1 review(s) completed after observations were made on the specific dates noted. All residents have the potential to be affected by this practice as it relates to infection control, however a facility wide audit was completed on 12/28/2015 and sixteen residents with diagnosis of diabetes and who also have orders to monitor their blood sugars have the potential to be affected. Nursing staff will be in -serviced by 1/26/2016 and will include a review of the policies and procedures related to the use of personal protective equipment (PPE). Hand hygeine including the use of hand sanitizer, glucose monitoring equipment: disinfect/ decontaminate procedure and bloodborne pathogens related to infection control standards of practice. Audits will be completed by the DON or designee that will monitor infection control practices three times per week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs. Peri Care: NA-C verbalized understanding on 12/16/2015 related to the standards of practice when assisting R61 with pericare needs. All residents who receive assist with hygeine needs have the potential to be affected. Nursing staff will be in - serviced by 1/26/2016 and will include a review of the	

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F 441	Continued From page 82 again obtained a reading of 146. LPN-D ask R76 to wait for insulin. LPN-D went out of room cleaned the glucometer briefly with a Super SANI-PDI Cloth wipe then wrapped with the Super SANI-PDI Cloth and set it on the top cart drawer still with same gloves drew the insulin from vial and went to room shut the door, came out disposed the syringe with same gloves document still wearing the same gloves. R76's MDS dated 10/15/15, indicated R76 was a diabetic and had no infections. R1: On 12/14/14, at 6:17 a.m. LPN-D then stated she was going to next to R1's room to do another blood sugar check. LPN-D still wearing the same gloves got to R1's room as she was going into the room surveyor intervened and asked nurse if she was supposed to wash her hands between gloves changes stated she usually would use the hand sanitizer then went into R1's room washed hands came out applied a pair of gloves. At 6:18 p.m. LPN-D went into room and set the glucometer on R1's left thigh and punctured the finger obtained a drop of blood got a reading of 108 came out of room removed the gloves after disposing the lancet and stripe into the sharps container took the gloves off, donned another pair of gloves without washing hands, recorded the reading then drew seven units of Novolog (medication used to control blood sugar) went into R1's room administered it on the left arm removed gloves outside the room and came back into the room and washed hands. At 6:22 p.m. when asked if she was supposed to wash her hands between residents and if she was supposed to wash her hands after glove change LPN-D stated "Yes. I	F 441	policies and procedures related to use of personal protective equipment (PPE). Hand hygiene including the use of hand sanitizer, and infection control standards of practice. Audits will be completed by the DON or designee that will monitor infection controlpractices three times per week for two weeks, then weekly. Audits will be reviewed during the quality assurance (QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs. Wound Care: On 12/16/2015 the pharmacy was notified and sent a new tube of Santyl to replace the soiled one. The wound care supplies were removed from the room and were replaced with new ones to ensure none were exposed to dirty linen. RN-B verbalized on 12/16/2015 understanding related to hand hygeine meeds and policy and procedure as it related to wound care. All residents who receive wound care have the potential to be affected. Nursing staff will be in -serviced by 1/26/2016 and will include a review of the policies and procedures related to the use of personal protective equipment (PPE). Hand hygiene including the use of hand sanitizer, wound care and treatment policy and procedure, and infection control standards of practice. Audits will be completed by the DON or designee that will monitor infection control practices three times per week for two weeks, then weekly. Audits will be reviewed during the quality assurance	

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F 441	Continued From page 83 was just rushing through as supper was coming up." LPN-D further stated "when I was trained we were trained to wipe the glucometer and wrap it and that's what I did as I was using them. I forgot the sanitizer in the other cart. It's ideal to wash with water or hand sanitizer." When asked about the barrier she acknowledged she had not used the barrier on R76's bedside table stated there was no blood all over the glucometer but acknowledged would have been ideal to use a barrier but was not sure as she would not remember if that had been addressed in the training and thought was sufficient to clean it after each use. When asked if she was supposed to walk down the hallway with used gloves LPN-D acknowledged she should have removed them. R1's MDS dated 11/24/15, indicated R1 was a diabetic and had no infections. R132 was observed on 12/15/15, at 11:44 a.m. Registered nurse (RN)-G was observed enter R132's room with a small tote which contained blood sugar supplies. Upon entering the room RN-G set the tote directly on the bedside pull table without a barrier and then got a paper towel retrieved a glucometer from the tote and set it next to the tote on the paper towel. After applied the stripe wiped R132's finger with alcohol then punctured it obtained a drop of blood and obtained a reading of 159. RN-G took gloves off tossed in garbage, came back gathered the supplies and LPN-E who was in the room at the rime took the glucometer wrapped in a paper towel brought it out of the room set it on the cart then then RN-G took the tote returned it into the third drawer without cleaning it then was observed wipe the glucometer tossed the wipe	F 441	(QA) meeting to determine if any trends are identified, and recommendations made for continued audits/ monitoring needs.	

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and then proceeded to get a Super SANI-PDI Cloth wipe wrapped around the glucometer and then washed her hands with the hand sanitizer. At 11:52 a.m. when asked if the tote was supposed to be placed directly on the bedside table and put back into the cart, RN-H and LPN-C present by the cart outside R132's room both stated the tote was supposed to have been cleaned on the bottom before it was stored. The nurses were all observed clean the cart and the tote. LPN-C stated she preferred the totes not to be taken into the rooms.

R132's MDS dated 10/12/15, indicated R132 was a diabetic and had no infections.

R13's blood sugar completion was observed on 12/16/15, at 7:38 a.m. LPN-B came in with gloves on and glucometer and supplies in hand to do blood sugar, LPN-B put glucometer on over bed table with no barrier, used the lancet device and obtained a blood sugar. LPN-B then removed her gloves, picked up supplies and let the room without washing hands. LPN-B entered the room with gloves on and gave insulin to R13, who was on the toilet. LPN-B left the room with gloves on.

R75's blood sugar observation was completed on 12/16/15, at 8:11 a.m. LPN-B was observed go into R75's room indicated was going to check the blood sugar came out applied gloves cleaned the glucometer with a Super SANI-PDI Cloth wipe briefly then went into the room and shut the door. LPN-B then obtained a paper towel and set it on the bedside pull table and set the glucometer, a whole bottle of glucometer stripes alcohol wipe and lancet. LPN-B then obtained one stripe from

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the bottle and applied to glucometer asked resident which finger then punctured it squeezed and obtained a drop of blood with reading of 134. LPN-B then still with the same gloves pick up the bottle of stripes (multiple-use) and the glucometer with used stripe on came out of the room tossed the bottle into the top drawer with all the supplies and clean glucometer's. Then cleaned the glucometer with the same gloves after touching the tip of the stripe with blood wrapped it then removed the gloves and used hand sanitizer. At 8:13 a.m. when asked about the bottle of stripes she had brought into the room and had touched it with the gloves stated "I should have not taken it to the room and should have removed my gloves before touching it." LPN-B acknowledged she should have changed her gloves before cleaning the glucometer.

R75's MDS dated 12/10/15, indicated R75 was a diabetic and had no infections.

R31:
On 12/14/15, at 11:59 a.m. RN-A entered R31's room with glucometer in hand. RN-A left the door open and placed glucometer on bedside table, washed R31's finger obtained blood. RN-A told R31the result of Blood sugar. RN-A returned to treatment cart,RN-A placed a paper towel on the treatment cart and wrapped glucometer in SANI-PDI wipe for two minutes.

R31's annual MDS dated 9/9/15, indicated R31 had diagnosis of diabetes which required daily insulin.

On 12/16/15, at 12:16 p.m. to 12:41 p.m. during an interview with the infection control RN-I when

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F 441	Continued From page 86 asked if she did go in with staff to observe cares RN-I stated she would go in and would go with the nurses during medication pass, "I have assigned a restorative aide to go in, and watch cares." RN-I stated staff had received training on the use of a barrier when using a glucometer in the resident room and staff was supposed to go with the supplies they needed only for the task as recommended by Centers for Disease Control (CDC). When asked if there was on-going training RN-I gave example of the glucometer cleaning training provided recently and indicated training is done on-line and staff had to have a check list checked off which the staff signed after she of the nurse had observed then complete the task appropriately. RN-I also stated staff had been trained "No gloves in the hallway" and training had been done for nursing assistant (NAs) on the use of personal protective equipment (PPE) and NA's had been trained to remove gloves, wash hands, put clean gloves again if coming in contact with fluids. RN-I stated she would expect the nurses to remove soiled gloves after removing the old dressing and wash hands then apply another pair to continue with the dressing change. Indicated the staff was supposed to go with the supplies they needed for the task as recommended by CDC. On 12/17/15, at 2:46 p.m. interim director of nursing (IDON) stated she would expect the nurses to not walk with gloves in the hallway, to have removed gloves, if gloves were soiled she expected the staff to wash hand and it not use hand sanitizer. IDON further stated the staff were supposed to follow policy with barrier use on bedside table when doing blood sugar checks.	F 441		

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F 441	Continued From page 87 Pericare: R61 was observed being wheeled into her room by NA-C on 12/16/15, at 8:51 a.m. from the dining room. At 8:55 a.m. R61 was observed open the bathroom door then came out. At 8:56 a.m. R61 was overheard resident call out "please help" and NA-C was observed go to room applied gloves and assisted resident into the toilet. R61 was heard void then stated "am done" NA-C then cued resident to stand then cued R61 she was going to apply a transfer belt around the waist then assisted resident to stand. NA-was observed use toilet paper to wipe resident bottom twice which was noted to have brown stool then with the same gloves adjusted R61's incontinent pad and pants then guided resident to seat on the wheelchair. NA-C still wearing the same gloves was heard indicate to R61 "you had a bowel movement." NA-C then touched the wheelchair armrests with the same gloves and as she wheeled resident through the door removed the gloves and wheeled resident to the sink located in the room and washed her hands and set resident to wash hands too. -At 9:02 a.m. When asked if she was supposed to wash her hands after providing pericare NA-C stated "Am sorry I was supposed to remove the gloves." NA-C acknowledged she should have washed her hands also. -At 9:11 a.m. when asked if the staff were supposed to wash hands after providing pericare and if staff were supposed to change gloves during cares the IDON stated "Yes." At 9:12 a.m. surveyor asked RN-B to clean the wheelchair armrest. Glucose Monitoring Equipment: Disinfect/Decontaminate effective July 2015, directed staff "Place the glucometer on the	F 441		

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overhead table on a clean surface, e.g paper towel, wax paper." For cleaning the glucometer the policy directed

"1. Use the disinfectant wipe to clean all external parts of the glucometer with gloves on.
2. Remove gloves.
3. Perform hand hygiene.
4. Don clean gloves
5. Obtain a second wipe and fresh paper towel.
6. Use the wipe to clean all external parts of the glucometer for the second cleaning.
7. Place the glucometer on the fresh paper towel.
8. Remove gloves.
9. Perform hand hygiene.
10. Place glucometer in appropriate storage until next blood glucose test..."

Hand Hygiene - Plain Soap and Water Handwash policy effective July 2015, directed:
"A plain soap and water handwash will be used:

· If hands are visibly soiled
· Before eating and after using the restroom
· If exposure to spores is suspect or proven e.g, C. difficile

A plain soap and water handwash or an alcohol hand rub may also be used:

· If hands are not visibly soiled
· Before having direct contact with residents
· Before inserting indwelling catheters, peripheral vascular catheters, other invasive devices that do not require a surgical procedure
· After contact with a resident's intact skin (e.g, when taking a pulse or blood pressure and lifting

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F 441	Continued From page 89 a resident) · After contact with body fluids or excretions, mucous membranes, non-intact skin and wound dressings if the hands are not visibly soiled · During resident care if moving from a contaminated- body site to a clean- body site · After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident · After removing gloves..." R13's cares were observed on 12/16/15, at 7:38 a.m. R13 was then lifted to the stand platform and rolled (transported) from the bed to the bathroom. R13 was then lowered to the toilet. NA-C then performed pericare for R13, she then removed the gloves, but did not wash her hands. R13 was admitted to the facility 5/31/14, with admission diagnoses of stroke with hemiplegia (loss of use of one side of the body) dysphagia (difficulty swallowing food and liquids) and apraxia of speech (difficulty with expressing thoughts). The quarterly MDS dated 11/13/15, indicated R13 was cognitively intact, moderately depressed and required extensive assist of two staff for transfer and toilet use. The annual Care Area Assessment (CAA) dated 3/6/15, indicated R13 was unable to participate in cares due to body habitus and refusals of care. R13 required assist of two staff and a stand assist lift to toilet, was usually incontinent and noncompliant with toileting schedule. The care plan dated 3/9/15, indicated assist of	F 441		

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two staff with EZ stand for bed/chair/toilet.
On 12/17/15, at 7:33 a.m. NA-C neither confirmed nor denied that she did not wash her hands when removing gloves.
R14's pericare was observed on 12/16/15, at 9:37 a.m. NA-B washed R14's periarea from front to back and then washed R14's bottom. NA-B changed gloves but did not did not wash hands prior to putting on fresh new gloves.

R14's MDS dated 12/8/15, indicated R14 required two person assist for toileting and personal hygiene and R14 had no behaviors of refusing care.

Wound care:
R14's MDS dated 12/8/15, indicated R14 was at high risk for pressure ulcers due to impaired bed mobility and impaired transfer. The MDS further noted R14 had an unstageable Stage 4 pressure ulcer. R14 required two person assist for transfers and bed mobility and had no behaviors of refusing care.

R14 wound care was observed on 12/16/15, at 9:28 a.m. It was noted that dressing supplies included a package of non sterile guaze, several 4x4 avino dressings, and a bottle of spray wound cleanser. There was a bag of dirty linen on top of the bucket of clean dressing supplies.

RN-B applied gloves and removed the soiled dressing. The dressing was dated 12/15/15, and had a dark stain on out side of dressing. RN-B did not wash their hands after they removed the soiled dressing nor did they change gloves. RN-B opened a new dressing with the soiled gloves and placed the dressing (still in its package) on the

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F 441	Continued From page 91 bed side table. RN-B placed Santyl (wound care product) on bedside table without a barrier. RN-B placed tape pieces on bed, then placed the dressing package on mattress. RN-B applied Santyl to the dressing the soiled gloves and then placed the Santyl tube on mattress (without a barrier). RN-B removed the soiled gloves and applied new gloves but did not wash their hands. RN-B applied dressing and dated it. RN-B removed gloves, did not wash hands, placed the tube of Santyl ointment in pocket. RN-B removed bag of soiled dressing supplies to the soiled utility room and washed their hands at 9:42 a.m. During interview on 12/16/15, at 9:45 a.m. RN-B verified the Santyl product was in the uniform pocket. RN-B stated, "No, I should have not put it on the bed. In a perfect world you would want to put down on a sterile sheet." RN-B also acknowlwdged the policy indicated to use a barrier such as a paper towel. "I should have placed it there instead of my pocket." RN-B placed Santyl in treatment cart from the now soiled pocket. RN-B also acknowledged the lack of handwashing after the removal of the soiled dressing. During interview on 12/17/15, at 2:07 p.m. the IDON stated, "It is not ok to place Santyl on a bed or bedside table without a barrier, or in your pocket and take to the soiled utility room and then place in the treatment cart. Residents should have their own tube of santle with their name on the tube or container in which it is contained. I expect the nurses to remove gloves after a soiled dressing change and wash hands or use sanitizer."	F 441		
F 456	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE	F 456		1/26/16

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F 456 SS=E	Continued From page 92 OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ice machines and microwaves were in good operating condition. This had the potential to affect 71 of 72 residents in the facility who ate out of the kitchen. Findings include: On 12/15/15, at 10:27 a.m. the second floor dining room ice machine was observed to be slowly dripping near the spout and the grate had a small area of white stain. In addition, the microwave had a small amount of food spilled on the inside food plate. On 12/15/15, at 10:25 a.m. nutrition services manager (NSM) stated he would check with the manufacturer regarding the ice machine. He also confirmed the ice machine was due to be cleaned and was cleaned on Tuesdays. He stated the microwave needed to be cleaned which was done daily. On 12/15/15, at approximately 10:28 a.m. NSM stated where ice formed inside the ice machine, it did not make a seal and dripped. He stated as the ice melted inside the machine it dripped through, and confirmed it dripped on the front of the third floor dining room machine near the spouts.	F 456	F 456 Microwaves have been replaced, and the ice machines were cleaned on 12/15/2015. Microwaves are utilized in the three dining rooms. Ice machines are on an on-going cleaning schedule. Staff will be in-serviced by 1/26/2016 as it relates to the policies and procedures of sanitary conditions related to the ice machines and the microwaves. Audits will be completed by the NSM and/or designee that will monitor the cleaning schedule three times a week for two weeks, then weekly. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	

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F 456	Continued From page 93 On 12/15/15, at 10:33 a.m. the fourth floor dining room microwave was observed to have the enamel plastic casing chipped and worn off on the inside door and inside front opening. NSM confirmed it should not be used and removed it from service. In addition, he stated the ice machine had a drip and did not have a gasket. As the ice began to melt it dripped and indicated he would check with the manufacturer. On 12/16/15, at 9:57 a.m. NSM stated they have three filters on the ice machines which were cleaned yesterday. On 12/16/15, at 3:20 p.m. the ice machines were observed to still be dripping. Facility nutrition services microwave procedure dated July 2015 indicated "will be maintained in a clean and sanitized condition... will be wiped out after each use and thoroughly cleaned twice per week or more often as needed." Facility nutrition services ice machine procedure dated July 2015 indicated "the ice machine, scoop, and storage container will be maintained in a clean and sanitary condition. The ice machine will be cleaned once per month or more often as needed." MDT5N25 & MDT5N40 user manual dated November 2008 indicated "the dispense area: spouts, sink, grill and splash panel will need periodic cleaning and maintenance. 2. The sink grill may be removed for washing and sanitizing." Undated dining services cleaning schedule indicated third and fourth floor microwaves were to be cleaned daily and the ice machines were to	F 456		

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F 456	Continued From page 94 be cleaned weekly.	F 456		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide an environment that was clean and in good repair 3 of 13 residents (R87, R43, R82). This also had the potential to affect 1 of 3 floors in which there were 13 of 26 residents who potentially could be affected for the South shower on third floor. Findings include: On 12/16/15, at 10:37 a.m. to 11:53 a.m. the environmental tour was conducted with the maintenance supervisor (MS), executive director (ED), housekeeping supervisor (HKS), executive director in training and housekeeping and laundry manager (HKLM). During the tour the following concerns that had been identified during stage I of the survey were verified: R87's grab bars secured to bed on 12/14/15, at 4:11 p.m. during room observation were observed to be padded with porous black uncleanable foam which was secured with black tape. The black tape was noted to be wrinkled and not creating a seal which exposed the adhesive part and rendered the foam portion to be an uncleanable surface. During the tour the executive director	F 465	F 465 Areas identified on the environmental tour on 12/16/2015 which included the shower room, the grab bar, the wheelchair, and the privacy currtain were all corrected immediately upon identification. The shower door will be corrected by 1/26/2016. A facility wide audit was completed and any areas identified will be corrected by 1/26/2016. Staff will be in-serviced by 1/26/2016 as it relates to the policies and procedures of environmental needs. Audits will be completed by the Director of Maintenance and Director of Housekeeping and/or designee that will monitor the shower rooms, grab bars, wheelchairs, and privacy curtain cleanliness, and shower room doors once a week for three weeks, and monthly thereafter. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued	1/26/16

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F 465	Continued From page 95 verified it and stated the grab bars would be replaced with lamb wool skin which can be washed and would provide padding to resident. R87's quarterly Minimum Data Set (MDS) dated 10/27/15, indicated R87 required extensive assist with bed mobility and transfers. R43's right wheelchair armrest was observed to be in ill-repair on 12/15/15, at 8:15 a.m. The vinyl was chipped which exposed the mesh underneath, making it an uncleanable surface, was observed with a thin coating of dust on the entire frame of the wheelchair and the seat was observed ripped/torn on the sitting part both the MS and ED verified stated would replace the seat and MS stated armrest would be changed. When asked how often the wheelchairs were cleaned MS and HKS stated deep cleaning was done monthly and at the time if any concerns was identified would be reported to MS to address and as needed. R43's quarterly MDS dated 9/11/15, indicated R43 had severely impaired cognition, was independent with transfers after set up and used a wheelchair and walker for locomotion. R82's privacy curtain on 12/14/15, at 2:04 p.m. had a large yellow stain on it. During the tour ED and housekeeping and laundry manager verified the yellow substance on the privacy curtain. When asked how often the privacy curtains were changed the housekeeping and laundry manager stated was done daily by housekeeping staff during the daily room cleaning and were changed as needed.	F 465	audits/monitoring needs.	

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	245417	A. BUILDING _____ B. WING _____	12/17/2015

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F 465	Continued From page 96	F 465		

R82's quarterly MDS dated 10/6/15, indicated R82 had severely impaired cognition and was occasionally incontinent of urine. R82 required one person assist with transfers, bed mobility and toileting.

South Shower rooms
During the environmental tour conducted on 12/16/15, at 10:37 a.m. to 11:53 a.m. the both the shower rooms were observed with the following concerns:
-The bottom of left shower room door was observed to have extreme water damage which caused the entire edge length to crack all along it.
-The shower room on the right was observed to have white yellow gooey substance on the soap holder on the wall, had a missing towel holder with some parts still screwed on the wall, the privacy curtain behind the door was observed to have multiple stains of brown matter. During the tour the housekeeping supervisor verified the findings. When asked how often the privacy curtains were changed the housekeeping and laundry supervisor stated was checked daily as the shower room was cleaned daily and never indicated if the shower was cleaned between residents. She also indicated the curtains were changed as needed. The executive director verified the missing towel holder.

Wheelchair Safety Checks policy effective July 2015, indicated "The center strives to check wheelchairs regularly foot proper operation and safety. When clinical or non-clinical staff notice loose hardware or other possible safety issues with the operation of a wheelchair, the resident should be removed from the potentially unsafe

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F 465	Continued From page 97 wheelchair, the wheelchair taken out of operation, and repair personnel should be contacted. The appropriate repair person will be notified. Regular preventative maintenance checks on wheelchairs will be performed monthly by the maintenance Department..."	F 465		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure all handrails were firmly secured to walls. This had the potential to affect 1 of 3 floors in which there were 20 of 26 residents who either were ambulatory or were in a wheelchair who used the handrails to propel themselves. Findings include: 3 North Hallway On 12/16/15, at 8:11 a.m. R76 was observed leave the dining room never took his walker with him and went out of the dining room to the hallway and was observed ambulate to his room as he grabbed the handrails along the hallway across from the DR and went into his room. -At 8:12 a.m. surveyor observed the screw of the handrail located right across from the dining room to be loose. When surveyor approached and touched the handrail, it was observed to be loose and not adhered to the wall for stability. On 12/16/15, at 10:37 a.m. to 11:53 a.m. during	F 468	F 468 The handrail identified as being loose was tightened on 12/16/2015 during the environmental tour. A faciltiy wide audit was completed and other areas identified were corrected immediately. Staff will be in-serviced on environmental needs related to handrails being firmly secured. Audits will be completed by the Director of Maintenance and/or designee that will monitor once a week for three weeks, and monthly thereafter. Audits will be reviewed during the quality assurance meeting to determine if any trends are identified, and recommendations made for continued audits/monitoring needs.	1/26/16

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F 468	Continued From page 98 the environmental tour the concern was brought to the facility attention and the maintenance supervisor (MS) verified the handrail was loose and immediately tightened the handrail. MS stated "Am very disappointed at myself. I walk through this hallways and check."	F 468		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on December 15, 2015. At the time of this survey, Robbinsdale Rehab & Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Please return the plan of correction for the Fire Safety Deficiencies (K-tags) to: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2016

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.

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 4-story building was determined to be of Type II(222) construction. It has no basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 72 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not	K 066		1/26/16

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K 066	Continued From page 2 responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, policy review and staff interview, the facility has failed to follow policy for the designated resident smoking in accordance with NFPA LSC (00) Edition Section 19.7.4, and the facility's smoking policy. This deficient practice could affect all residents, staff and visitors if an fire incident were to occur in the smoking area. Findings include: On facility tour between 1:30 PM and 4:30 PM on 12/15/2015, it was observed by MDH and myself (Deputy Fire Marshal) that the facility staff need to be re-educated on the smoking policy for re-evaluating residents that are allowed to smoke as supervised and unsupervised. The following items shall be addressed: 1. Individuals that are supervised are not allowed to carry smoking items on the person. It was stated by staff that a supervised resident had	K 066	The submission of this plan of correction is not an admission by the provider of any fact or conclusion set forth in the Statement of Deficiency. This Plan of Correction is being submitted because it is required by law. However, evidencing Robbinsdale Rehabilitation and Care Center good faith, the facility offers the following plan of correction and has achieved substantial compliance in each of the areas addressed by January 26, 2016. K66 A description of what has been, or will be done to correct the deficiency. Each resident who smokes has been educated on the smoking policy with the emphasis of properly storing smoking items when not in use, no smoking with oxygen on, and proper disposal of	

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K 066	Continued From page 3 smoking material on them. 2. It was observed improper disposal of cigarette butts on ground around the smoking area and inside of the trash can. 3. It should be made clear to staff that smoking while oxygen is in use is prohibited while smoking. It was stated by staff that using oxygen while smoking is allowed. This deficient practice was verified by the Administrator.	K 066	cigarette butts. Staff has been educated on the smoking policy, proper storage of smoking items, and the difference of supervised and unsupervised smoking individuals. Staff has also been educated that smoking with oxygen is prohibited. The actual, or proposed completion date. The correction date will be 1/26/2016 The name and/ or title of the person responsible for correction and monitoring to prevent a reoccurance of the deficiency. The director of Social Service and or designee will be responsible to prevent a reoccurance by monitoring the residents' storage of smoking items and compliance of smoking policy. Director of Maintenance and/ or designee will be responsible to prevent a reoccurance by monitoring the smoking area for cleanliness and compliance of cigarette disposal.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and	K 067	K67 A waiver has been submitted with the Plan of Correction	1/26/16

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K 067	Continued From page 4 NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all 72 residents. Findings include: On facility tour between 1:30 PM and 4:30 PM on 12/15/2015, observations and staff interview revealed that the corridors had supply air only and the resident rooms had no supply or return air and toilet exhaust that runs continually. The air supply and return configuration uses the corridors as a return plenum. This deficient practice was verified by the Administrator at the time of the inspection.	K 067		