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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B3HD
Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245275**
2. STATE VENDOR OR MEDICAID NO. (L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDENBROOK OF EDINA**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/22/2017** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **85** (L18)
13. Total Certified Beds **85** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(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 :
Sandra Tatro, HFE NEII 09/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **05/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/19/2017** (L33)

DETERMINATION APPROVAL

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

CCN: 24 5275

On June 5, 2017, a Health Post Certification Revisit (PCR) was completed and verified the facility achieved and maintained compliance with Federal certification requirements. Based on our PCR we have determined the facility has corrected all deficiencies issued pursuant to the standard survey completed April 13, 2017, effective May 25, 2017. As a result of this visit, the Department discontinued the Category 1 remedy of state monitoring, as if May 25, 2017.

In addition, we recommended to the CMS Region V Office the following enforcement action as it relates to the remedy outlined in our letter of May 4, 2017.

- Civil Money Penalty for deficiency cited at F314, be imposed.

Effective May 25, 2017 the facility is certified for 85 skilled nursing facility beds.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245275

September 22, 2017

Mr. John Doughty, Administrator
Edenbrook of Edina
6200 Xerxes Avenue South
Richfield, MN 55423

Dear Mr. Doughty:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 25, 2017 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 22, 2017

Mr. John Doughty, Administrator
Edenbrook of Edina
6200 Xerxes Avenue South
Richfield, MN 55423

RE: Project Number S5275027

Dear Mr. Doughty:

On May 4, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 9, 2017. (42 CFR 488.422)

In addition, on May 4, 2017, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on April 13, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On June 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 25, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2017, as of May 25, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 25, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of May 4, 2017:

- Civil money penalty for the deficiency cited at F314, be imposed. (42 CFR 488.430 through 488.444)

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

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

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

Sincerely,

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

Enclosure(s)

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 22, 2017

Mr. John Doughty, Administrator
Edenbrook of Edina
6200 Xerxes Avenue South
Richfield, MN 55423

Re: Reinspection Results - Project Number S5275027

Dear Mr. Doughty:

On June 5, 2017, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 13, 2017. At this time, these correction orders were found corrected.

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

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

Sincerely,

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

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 20, 2017

Mr. John Doughty, Administrator
Edenbrook of Edina
6200 Xerxes Avenue South
Richfield, Minnesota 55423

Subject: Edenbrook of Edina - Independent Dispute Resolution (IDR)
CMS Certification Number (CCN): 24 5275
Project Number: S5275027

Dear Mr. Doughty:

This is in response to your letter of May 11, 2017, in regard to your request of an informal dispute resolution (IDR) for the Federal deficiencies at tag F314 and F353 issued pursuant to the survey event B3HD11, completed on April 13, 2017.

The information presented with your letter, the CMS 2567 dated April 13, 2017 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:

F314-G 42 CFR §483.25 (b)(1)-Pressure Ulcers: Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable; and
(ii) A resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

Summary of the facility's reason for IDR of this tag: In the written documentation submitted by the facility, dated 5/14/17, the facility requested the tag be removed or lowered in severity, indicated they felt R35's skin injuries were unavoidable due to multiple co-morbidities, a long standing history of rubbing and scratching herself raw, especially her lower extremities, incontinent of urine and bowel and frequently refused to accept cares and assessments. The facility also indicated as proof of good care provided by the facility, they alleged R35 did not have any skin breakdown on her buttocks or peri-area.

Summary of findings: R35 had diagnoses, which included Lichen Simplex Chronicus (neurodermatis, as result of chronic skin irritation), unspecified dementia with behavioral disturbance and pruritus. R35's annual Minimum Data Set (MDS) dated 2/7/17 indicated R35 had moderate cognitive impairment, required extensive assistance for activities of daily living and did not ambulate. The MDS indicated R35

had daily behaviors, which did not put R35 at significant risk for physical illness or injury, did not significantly interfere with residents care and did not reject care. Further, R35's MDS listed R35 was at risk for the development of pressure ulcers and did not have a current pressure ulcer. On 3/2/17, R35 developed an unstageable pressure ulcer on the right inner ankle. R35 did not have a comprehensive skin assessment completed after the development of the unstageable pressure ulcer, evaluating the causal factors, risk factors, and the development of interventions such as a repositioning schedule, alternatives for pressure relief while in bed and chair to attempt to prevent the development of further pressure ulcers and heal the present pressure ulcer. R35's right inner ankle pressure ulcer deteriorated, had exposed tendon on 3/31/17 and R35 had developed a second unstageable pressure ulcer on right inner heel at that time. In addition, approximately one week prior to survey, R35 developed a deep tissue injury of the left heel.

R35 was observed on several occasions during survey to remain in the same position, with feet dependent or resting directly on a firm surface, for prolonged periods,(i.e. 3 hours and 16 minutes, 2 hours and 50 minutes) without staff assisting or offering to assist R35 to reposition. Staff required prompting to complete repositioning for R35 during the observations. In addition, R35 developed a stage 2 pressure ulcer on 4/12/17 (during survey) on the left ischial tuberosity. Further, the facility failed to implement R35's current wound treatment orders, which included the use of calcium arginade.

R35 developed multiple pressure ulcers in the facility, and the facility failed to comprehensively assess R35 after the development of the multiple pressure ulcers and failed to develop interventions in an attempt to heal the current pressure ulcer (s) and prevent the development of further pressure ulcers. In addition, the facility failed to implement current orders for treatment of the pressure ulcers.

This is a valid deficiency at this tag and at the correct scope and severity of G.

F353-F 42 CFR §483.35 (a)(1) Sufficient Staff: The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived, licensed nurses; and
(ii) other nursing personnel, including but not limited to nurse aides

Summary of facility's reason for IDR dispute: The facility indicated they had consistent nursing patterns based on the individual needs of the floors, and had staffed appropriately. They indicated the facility had not lost any nurses since 3/6/17 and continue to hire certified nursing assistants. The facility indicated the deficiencies at F241, F279, F282, F309, F312, F313, F314, were not staffing issues, but possible poor performance by staff. Since 3/6/17, the facility has hired 23 new staff member, made changes to room occupancy and do not feel the new management company has had

negative impact on the nurse staffing within the building. In addition, the facility felt comments made by both staff and family members were reflections of frustration with transition when new management took over ownership of the facility.

Summary of findings: During the course of the survey, thru both resident and family interviews, there were many complaints regarding not enough nursing staff to meet the needs of the residents. The interviews revealed residents not receiving appropriate assistance with cares such as toileting, personal hygiene, and dressing. Family members reported when they were visiting their family in the facility, having to wait for long periods for call light response(>30 minutes), and their family member had not received assistance with such things toileting and transferring. Several staff indicated frequently the facility was short staffed, inadequate training for new staff and at times there had been one nurse to pass medications and provide cares for 17 residents. Staff indicated they had informed the director of nursing of their concerns in the past. In addition, the nurse practitioner stated she had discussed her concerns regarding staffing and cares with the director of nursing in the past.

In addition to mandating overtime for staff to cover shifts, the facility had modified the occupancy on each floor, and was hiring new staff. The director of nursing indicated the facility attempted to staff at a resident to staff ratio of 10:1 ratio, however, she indicated specific floors were more impacted than others by the staffing challenges. The executive director indicated the facility manager on duty had stopped monitoring call lights, dining service in March, however; indicated a not longer than seven minute response time for call lights was acceptable.

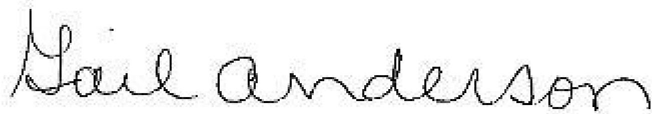
Although the facility was hiring new staff, mandating overtime and modifying occupancy on each floor, the facility did not provide sufficient nursing staff to meet the needs of the residents.

This is a valid deficiency at this tag and at the correct scope and severity of F.

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, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
1505 Pebble Lake Road, Suite 300
Fergus Falls, MN 56537
Telephone: 218-332-5140 Fax: 218-332-5196

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Licensing and Certification File
Susie Haben, Metro D District Supervisor

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B3HD
Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245275**
2. STATE VENDOR OR MEDICAID NO. (L2) **964043600**

3. NAME AND ADDRESS OF FACILITY
(L3) **EDINA CARE & REHAB CENTER**
(L4) **6200 XERXES AVENUE SOUTH**
(L5) **RICHFIELD, MN** (L6) **55423**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **04/13/2017** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **85** (L18)
13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(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 :
Jane Teipel, HFE NEII 05/18/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/19/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5275

On April 13, 2017 a standard survey was completed by the Departments of Health and Public Safety to verify compliance with Federal participation regulations. The most serious deficiency was cited at a scope and severity level of G (isolated deficiencies that constituted actual harm that was not immediate jeopardy), whereby significant corrections were required.

As a result of this survey, the Department imposed the Category 1 remedy of state monitoring, effective May 9, 2017.

In addition, we recommended to the CMS Region V Office the following enforcement remedy for imposition:

- Civil Money Penalty for deficiency cited at F314.

Refer to the CMS 2567 along with the facility's plan of correction.Post Certification Revisit to follow.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 4, 2017

Mr. John Doughty, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, MN 55423

RE: Project Number S5275027

Dear Mr. Doughty:

On April 14, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS 2567, whereby significant corrections are required.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Maria King, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Mankato Plaza
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001-7789
Email: maria.king@state.mn.us
Phone: (507) 344-2716
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; OR
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; OR
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey OR deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; OR
- A facility is classified as a Special Focus Facility (SFF) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 9, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by July 14, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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:

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING ______ B. WING ______	04/13/2017 04/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH** **RICHFIELD, MN 55423**

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 157		5/25/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/11/2017

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

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F 157	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promptly notify the physician when a pressure ulcer developed and worsened for 1 of 1 residents (R35) reviewed. Findings include: R35's progress notes from 3/6/17, to 4/11/17, identified on 3/6/17, R35's right inner malleolus was painful to touch and tender and there was no notation regarding an update to physician. On 4/1/17, a skin check was completed with documentation of: "Other right heel-pressure stage unstagable, right ankle (inner) pressure-	F 157	Potentially could affect any resident in the facility. -R35 passed away prior to the receipt of SOD. -Policies and procedures reviewed and updated and are currently up to date. -Training provided to staff. Re: Updating MD of change of condition. -2-3 Audits of skin assessment being completed. Refusal of skin assessments to be charted in EMR. Audits to be completed weekly x 3. Then, monthly. -Audit results to be reviewed at QAPI for determination of compliance and the need	

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F 157	Continued From page 2 stage II" and identified no new skin areas. The following day on 4/2/17, documentation identified that the dressing change to right ankle was completed and had a large amount of yellowish drainage from the wound site. Documentation lacked evidence that the provider had been notified. On 4/6/17, the progress note identified the right ankle dressing change was completed and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated. Weekly wound care specialist evaluation documentation reviewed from 3/2/17, to 4/7/17 indicated the provider was aware of R35's right medial ankle pressure ulcer on 3/2/17 and right medial heel on 3/31/17. On 4/11/17, at 3:20 p.m. the DON assessed R35's skin condition. The DON described R35's skin as: right upper buttock was open and excoriated from moisture; left ischial tuberosity is boggy and non-blanchable; the left bottom buttock is reddened but blanches; right ischial tuberosity is blanchable; right lower extremity has sores and scabs which have Tegaderm dressings on them; right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON verified was soiled with blood and wound drainage. After the NAs and the DON left the room, licensed practical nurse (LPN)-C and LPN-B entered at 3:45 p.m. to complete a right ankle dressing change. LPN-C described the wound as "reddened with discoloration on the edges" and measured 5 (centimeters) cm x 4 cm x 1.5 cm.	F 157	to continue. -DON or designee will be responsible for audits. -Date of compliance May 25, 2017.	

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F 157	Continued From page 3	F 157		

R35 screamed out, "That hurts!" during the dressing change.

On 4/12/17, at 10:19 a.m. the DON completed an assessment of the resident's skin condition. The DON stated the left ischial tuberosity had superficial skin loss over the previously identified Stage I on 4/11/17. The DON stated although she noted the Stage I pressure ulcer, she did not notify the physician or complete any related paperwork at that time. R35 moaned, tightened her jaw and had furrowed brows when assisted to turn to her left side. The DON then observed the left heel, which she stated was a suspected deep tissue injury measuring 1 cm x 1 cm x 1 cm. R35 reported the area was painful to touch.

On 4/12/17, at 1:44 p.m. nurse practitioner (NP)-A stated she was new to the facility and unfamiliar with R35. NP-A stated it was an expectation the staff would contact the NP with new skin alterations, but had not been informed of any problems with R35's skin since she began seeing the resident on 4/3/17. If skin alterations were observed, NP-A would institute orders to off load pressure and implement pressure relieving interventions. If a new wound had developed, she would potentially order a Mepilex dressing.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A. He reported he saw R35 for the first time on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. MD-A expected to be notified of significant decline in wounds. It was also expected daily dressing changes would be performed on R35's right

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F 157	Continued From page 4 ankle. MD-A reported R35 had a Stage IV ankle ulcer, and would have increased in size/severity without appropriate dressing changes. It was MD-A's impression the staff were elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks. On 4/13/17, at 12:30 p.m. the DON stated her expectation was the nurse should immediately notify the NP when the skin alteration was observed, as the NP ultimately oversaw care for R35. The DON stated R35 experienced pain with dressing changes. The facility's 4/21/14, Chalet Living and Rehab Wound Care Program policy and procedure indicated the facility would "initiate wound care treatment upon identification of the wound with physician's order and to refer to the wound care specialist in a timely fashion."	F 157		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who self-administered medications were assessed as capable to do so for 1 of 1 (R53) resident who self-administering medication.	F 176	Residents wishing to self administer nebulizers have the potential to be affected. -R53 has had a self administration assessment completed.	5/25/17

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F 176	Continued From page 5 Findings include: R53 was interviewed on 4/10/17, at 5:08 p.m. when licensed practical nurse (LPN)- A brought in R53's evening medications. The medications included an Ipratropium-Albuterol nebulizer treatment. LPN-A looked at the nebulizer mask and reported there was still medication left in the mask. Without re-starting the treatment and ensuring R53 received all of the medicine, LPN-A left the room. LPN-A then documented that the Ipratropium-Albuterol nebulizer was given on R53's medication administration record (MAR). On 4/10/17, at 7:21 p.m. LPN-A stated that he should have set up the nebulizer treatment for R53 but did not because the resident still had medication left in his nebulizer mask. R53's physician orders included Ipratropium-Albuterol Solution 0.5-2.5(3) milligrams/3 milliliters, 1 vial inhale orally four times a day for chronic obstructive pulmonary disease. R53's record also lacked evidence the resident had been assessed for self-administration of medications, and R53's current care plan did not reflect the resident was capable and chose to self-administer the nebulizer treatment. The director of nursing (DON) stated on 4/12/17, at 2:30 p.m. R53 was able to self-administer medications. However, at 3:18 p.m. the DON verified the staff had not completed an assessment that showed R53 was capable of self-administering the nebulizer treatment. 4/13/17, at 11:01 a.m. the DON verified LPN-A	F 176	-Staff have been educated on completion of self administration assessment prior to allowing self administration. -2-3resident audits will be done 1-2 times per week/audits to be completed x 1 month on residents self administering nebulizers. -DON or designee is responsible for audits. Audits to be reviewed no less than quarterly at QAPI for determination of compliance and need to continue. -Date of compliance 5/25/2017.	

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F 176	Continued From page 6 should have ensured the nebulizer treatment was completed, or documented R53 did not receive the medication. The facility's undated Self-Administration Medication Policy and Procedure directed "A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate."	F 176		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.	F 225		5/25/17

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F 225	Continued From page 7 (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and 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 injuries of unknown origin or allegations of neglect or abuse	F 225	Alleged tag could potentially affect all residents. -OHFC reports were filed on R75 and	

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F 225	Continued From page 8 to the facility administrator and designated State agency (SA) for 1 of 1 resident (R42) reviewed for abuse prohibition. Findings include: R42 sustained a bruise on 3/19/17, on her left knee measuring 4.3 centimeters (cm) long by 2.3 cm wide according to an incident report dated 3/29/17. The report indicated that on 3/19/17, nursing assistant (NA)-B noted the bruise and reported it to registered nurse (RN)-A. R42 stated she was not sure how she sustained the bruise when RN-A asked how it had happened. However, R42 also stated she did not like being "grabbed out" of her wheelchair. A Witness/Observer Statement dated 3/19/17, by NA-B noted while assisting R42 with morning cares, she reported to NA-B she was upset over the way she was treated the previous evening. NA-B observed a bruise on R42's left knee which was reported to RN-A. NA-B was unsure whether RN-A had done anything with the report, therefore also reported it to his supervisor, NA-D who interviewed R42. The facility was asked but could not provide evidence the administrator had immediately been notified of the allegation by R42, and had not been notified three days later on 3/22/17. LSW-A submitted at report to the SA on 3/22/17. NA-B was interviewed on 4/12/17, at 10:00 a.m. and stated that on the morning of NA-B stated on the morning of 3/19/17, R42 told him she had a bruise on her left knee and was upset about her cares the night before, explaining the NA's were abrupt. I reported it immediately to RN-A and then to NA-D.	F 225	R42. -Dispositions of "no further action taken" have been received from OHFC. -Policy has been reviewed and is up to date. -Staff were reeducated on importance of immediately reporting resident injuries including list of types of injuries that must be reported. -On call process revised to include immediate call to DON and ED of all suspected abuse. -OHFC report log updated and now includes section of when administrator or ED was updated on the issue. -Staff background checks have been completed. HR is using a spreadsheet to audit that background checks are completed on new hire employees. -Multiple staff have the ability to file VA reports and have been trained in same. -In the event one is unable to make report, the background reporter can and will make report for them. -2-3 Audit of OHFC timeliness will be done weekly x 4, monthly x 2 and reviewed quarterly at QAPI for determination of compliance and need to continue. -Social services and ED or designee will be responsible for audits. -Date of compliance 5/25/2017.	

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F 225	Continued From page 9	F 225		

Continued From page 9

During an interview conducted on 4/12/17, at 9:19 a.m. RN-A stated he did not remember being informed of a bruise on R42 at any time.

During an interview conducted on 4/13/17, at 8:16 a.m. the DON stated she was the nurse on call the night the incident occurred and was reported to me on 3/19/17, by NA-D and was not reported to the MDH until 3/22/17. We have since changed our process regarding reporting incidents to the MDH. We should have reported it right away to the DON, Executive Director and the MDH which was not done. The facility could not provide documentation as to the nurse on call being notified.

During an interview on 4/11/17, at 1:14 p.m. R42 stated she was attacked sometime last winter outside. It was younger girls and they climbed up on me and hit my legs. They were nasty young people. I felt panicky as I had never been attacked before. There may have been three people. I reported it right away to RN-A.

During an interview on 4/13/17, at 12:02 p.m. Executive Director stated he did not recall if he was apprised of the incident to R42 which occurred on 3/19/17, but he did remember the incident. He further stated in this type of incident the facility is to call the nurse on call and they should contact the DON, LSW and myself. We then discuss it and determine if it needs to reported to the MDH.

During an interview on 4/13/17, at 1:04 p.m. Executive Director stated he could not confirm or deny if he had been notified of the incident involving R42 on 3/19/17, but the policy is to

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report incidents like this within 24 hours and that was not done.

During an interview on 4/12/17, at 9:25 a.m. LSW-B stated it was my understanding that a NA reported a bruise to R42's left knee on 3/19/19, and I was notified on 3/22/17. The facility policy indicates that if a bruise is noted the staff would notify LSW or the DON to start an investigation and that did not happen in this instance.
Based on interview and document review, the facility failed to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1 resident (R54) incident reports reviewed.

Findings include:

R54 reported she had been abused at the facility when interviewed on 4/11/17, at 8:36 a.m. R54 alleged her roommate, R74 began hitting her and being physically abusive. R54 immediately reported it to a nurse. R54 moved to a different room for the weekend and then R74 was moved to a different room the following Monday.

R54's medical diagnoses on the admission record included anxiety disorder, major depressive disorder, borderline personality disorder, bipolar disorder. R54's minimum data set (MDS) from 3/7/17, identified her to be cognitively intact. The care plan printed 4/12/17, and provided by the facility as current addressed R54 being a vulnerable adult including the following interventions: Remove from potentially abusive situations, observe for and implement interventions to minimize and prevent re-occurrence, remove individuals to rooms or private areas for persistent &/or inappropriate

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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behaviors.

The incident documented in progress note from care center dated 3/31/17, identified "Resident had moved to room 223 and will be staying over the weekend for her safety. Resident's roommate was verbal/physical aggression toward her, and for the concerns of her safety, the RN on call agreed to place her to 223 temporary."

An investigative report provided by the facility identified resident to resident abuse. The incident occurred on 3/31/17, and was reported to the state agency on 4/1/17, by licensed social worker (LSW)-A. R54 stated R74 backed her into a corner, hit her and tried to punch her. R54 ran out of the room to alert the nurses. R74 tried to hit staff members as well. No injuries noted to R54. R54 moved to another room for the weekend, on Monday when private room available R74 was moved to a private room. No further incidences noted.

On 4/13/17, at 10:48 a.m. the director of nursing (DON) stated registered nurse (RN)-E let the her know immediately about this abuse incident and LSW-A was called. LSW-A was not able to get the report filed due to internet issues, however she was called immediately regarding this abuse incident. The abuse incident was reported to the state agency the next morning. The DON stated the facility recently changed abuse reporting. Nurses should the call on-call nurse and the on-call nurse calls everyone else like the DON, administrator, social worker, MD, etc. The DON and LSW-A will collaborate on if they should report abuse incident to the state agency. LSW-A will typically be the one to submit abuse report. The DON stated they report abuse incidents as

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soon as possible.

Resident/client/participant protection policy and procedure for the facility dated as last revised in 12/12, stated employees must always report abuse immediately to the supervisor or the building supervisor. The DON will be contacted per protocol and will involve LSW in decision making and will be reported to the state reporting agency in accordance to the state law. The policy also identified if the resident to resident altercation was a willful act, the resident's intent was to cause harm or wanted to hurt the other individual, a willful infliction of injury this altercation should then be reported, even if there is no injury. The facility must minimize and monitor to prevent reoccurrence.

The policy also identified employees must always report alleged abuse/neglect immediately to the Supervisor or the Building Supervisor. The Executive Director/ or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substantiated, it will be reported to the registry or licensing board.
Based on interview and record review the facility failed to complete criminal background checks on new hires for one of five employees (DA-A) reviewed.

Findings include:

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F 225	Continued From page 13 During a review of employee records and interview with human resource (HR) director on 4/12/17, at 8:36 a.m. one employee/dietary aide (DA)-A, whose date of hire was 3/9/17, did not have a completed background check in the employee file. DA-A was on the schedule and had worked in the facility. DA-A had not been supervised or with another staff person at all times. HR explained the "expectation is to have the background completed for all staff. I can see that I will need to do an audit to make sure this was done". At 4/12/17 11:01 a.m. HR reported this employee was removed from the schedule pending her completed background check. The policy "Pre-Employment Background Screening", revised 7/1/12, identified potential employees would receive job offers contingent upon the satisfactory completion of a background screening.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95,	F 226		5/25/17

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F 226	Continued From page 14 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1 resident (R42). Findings Include: The facility's Policy and Procedure for: Resident/client/participant Protection - selection Reporting and Response, revised 12/12, read: Employees must always report alleged abuse/neglect (i.e. incidents, mistreatment, abuse, neglect, injuries of unknown origin, and misappropriation of resident/client/participant property) immediately to the Supervisor or the Building Supervisor. The Executive Director/ or designated representative must be contacted immediately by Supervisor or reporter regarding	F 226	Alleged tag could potentially affect all residents. -OHFC reports were filed on R75 and R42. -Dispositions of "no further action taken" have been received from OHFC. -Policy has been reviewed and is up to date. -Staff were reeducated on importance of immediately reporting resident injuries including list of types of injuries that must be reported. -On call process revised to include immediate call to DON and ED of all suspected abuse. -OHFC report log updated and now includes section of when administrator or ED was updated on the issue. -Staff background checks have been completed. HR is using a spreadsheet to	

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F 226	Continued From page 15 all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. Director of Nursing will be contacted per protocol and will involve Social services or designee. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substantiated, it will be reported to the registry or licensing board. Documentation: Include who was notified and the time the notification occurred. Include social services or designee in the notification. An incident report dated 3/29/17, indicated on 3/19/17, nursing assistant (NA)-B noted R42 had a bruise on her left knee and reported it to registered nurse (RN)-A. Bruise measured 4.3 centimeters (cm) long by 2.3 cm wide. When R42 was asked by nurse how it could have happened she stated she was not sure how it happened. R42 also stated she did not like being grabbed out of her wheelchair. A Witness/Observer Statement dated 3/19/17, NA-B noted while doing morning cares on R42, she related that she was upset with previous evening's treatment after supper. A bruise was noted on R42's left knee which was reported to RN-A but NA-B was unsure whether RN-A followed through. NA-B then reported incident to his supervisor NA-D who consulted with R42. The facility could not provide any evidence of the director of nursing (DON), social services (SS) or Executive Director being notified of incident until 3/22/17. The incident was submitted to the Minnesota Department of Health (MDH) on 3/22/17, by SS-A.	F 226	audit that background checks are completed on new hire employees. -Multiple staff have the ability to file VA reports and have been trained in same. -In the event one is unable to make report, the background reporter can and will make report for them. -2-3 Audit of OHFC timeliness will be done weekly x 4, monthly x 2 and reviewed quarterly at QAPI for determination of compliance and need to continue. -Social services and ED or designee will be responsible for audits. -Date of compliance 5/25/2017.	

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F 226	Continued From page 16 During an interview conducted on 4/12/20, at 10:00 a.m. NA-B stated on the morning of 3/19/17, R42 told him she had a bruise on her left knee and was upset about her cares the night before and the NA's were abrupt. I reported it immediately to RN-A and then to NA-D. During an interview conducted on 04/12/17, at 9:19 a.m. RN-A stated he did not remember being told about a bruise on R42 at any time. During an interview conducted on 4/13/17, at 8:16 a.m. DON stated she was the nurse on call the night the incident occurred and was reported to me on 3/19/17, by NA-D and was not reported to the MDH until 3/22/17. We have since changed our process regarding reporting incidents to the MDH. We should have reported it right away to the DON, Executive Director and the MDH which was not done. The facility could not provide documentation as to the nurse on call being notified. During an interview on 4/11/17, at 1:14 p.m. R42 stated she was attacked sometime last winter outside. It was younger girls and they climbed up on me and hit my legs. They were nasty young people. I felt panicky as I had never been attacked before. There may have been 3 people. I reported it right away to RN-A. During an interview on 4/13/17, at 12:02 p.m. Executive Director stated he did not recall if he was apprised of the incident to R42 which occurred on 3/19/17, but he did remember the incident. He further stated in this type of incident the facility is to call the nurse on call and they should contact the DON, SS and myself. We then discuss it and determine if it needs to reported to	F 226		

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the MDH.

During an interview on 4/13/17, at 1:04 p.m. Executive Director stated he could not confirm or deny if he had been notified of the incident involving R42 on 3/19/17, but the policy is to report incidents like this within 24 hours and that was not done.

During an interview on 4/12/17, at 9:25 a.m. SS-B stated it was my understanding that a NA reported a bruise to R42's left knee on 3/19/19, and I was notified on 3/22/17. The facility policy indicates that if a bruise is noted the staff would notify SS or DON to start an investigation and that did not happen in this instance.
Based on interview and document review and interview, the facility failed to implement their policy to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1 resident (R54) incident reports reviewed.

Findings include:

The facility Resident/Client/Participant Protection policy and procedure dated as last revised in 12/12, stated employees must always report abuse immediately to the supervisor or the building supervisor. The DON will be contacted per protocol and will involve LSW in decision making and will be reported to the state reporting agency in accordance to the state law. The policy also identified if the resident to resident altercation was a willful act, the resident's intent was to cause harm or wanted to hurt the other individual, a willful infliction of injury this altercation should then be reported, even if there is no injury. The policy further identified it was

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F 226	Continued From page 18 possible for a willful act to be committed by someone with dementia. The facility must minimize and monitor to prevent reoccurrence. The policy also identified employees must always report alleged abuse/neglect immediately to the Supervisor or the Building Supervisor. The Executive Director/ or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substantiated, it will be reported to the registry or licensing board. R54 reported she had been abused at the facility when interviewed on 4/11/17, at 8:36 a.m. R54 alleged her roommate, R74 began hitting her and being physically abusive. R54 immediately reported it to a nurse. R54 moved to a different room for the weekend and then R74 was moved to a different room the following Monday. R54's medical diagnoses on the admission record included anxiety disorder, major depressive disorder, borderline personality disorder, bipolar disorder. R54's minimum data set (MDS) from 3/7/17, identified her to be cognitively intact. The current care plan provided as current addressed R54 being a vulnerable adult including the following interventions: Remove from potentially abusive situations, observe for and implement interventions to minimize and prevent re-occurrence, remove individuals to rooms or private areas for persistent &/or inappropriate	F 226		

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behaviors.

The incident documented in progress note from care center dated 3/31/17, identified "Resident had moved to room 223 and will be staying over the weekend for her safety. Resident's roommate was verbal/physical aggression toward her, and for the concerns of her safety, the RN on call agreed to place her to 223 temporary."

An investigative report provided by the facility identified resident to resident abuse. The incident occurred on 3/31/17, and was reported to the state agency on 4/1/17, by licensed social worker (LSW)-A. R54 stated R74 backed her into a corner, hit her and tried to punch her. R54 ran out of the room to alert the nurses. R74 tried to hit staff members as well. No injuries noted to R54. R54 moved to another room for the weekend, on Monday when private room available R74 was moved to a private room. No further incidences noted.

On 4/13/17, at 10:48 a.m. the director of nursing (DON) stated registered nurse (RN)-E let the her know immediately about this abuse incident and LSW-A was called. LSW-A was not able to get the report filed due to internet issues, however she was called immediately regarding this abuse incident. The abuse incident was reported to the state agency the next morning. The DON stated the facility recently changed abuse reporting. Nurses should the call on-call nurse and the on-call nurse calls everyone else like the DON, administrator, social worker, MD, etc. The DON and LSW-A will collaborate on if they should report abuse incident to the state agency. LSW-A will typically be the one to submit abuse report. The DON stated they report abuse incidents as

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F 226	Continued From page 20 soon as possible.	F 226		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal cares in a manner which promoted privacy and dignity for 2 of 4 residents (R1, R49) observed for activities of daily living (ADL's), and to provide a dignified dining experience for 1 of 13 residents (R49) served in the 3 north (3N) dining room. Findings include: R1 was observed receiving morning cares on 4/12/17, at 7:18 a.m. by nursing assistant (NA)-L. R1 was lying in the bed closest to the door. The room had two large windows, one of which faced an adjacent apartment complex. NA-L provided peri care to R1 without shutting the window shades or pulling R1's privacy curtain. NA-L removed R1's gown walked across the room to retrieve clothing items for R1 leaving her upper and lower private areas exposed to anyone who may have entered the room or potentially view from the outside. R1's care plan dated 3/9/17, revealed she dementia, severely impaired decision making abilities with short and long term memory loss,	F 241	All residents have the potential to be affected by this. -R1 alleged deficiency was corrected at time of survey. -Facility policy on privacy during cares has been reviewed and is correct. -R49 care plan does have finger foods to be offered per residents preference. -Staff were educated on importance of providing privacy with cares, this includes review of residents rights related to privacy and dignity. -Care plans are reviewed and updated to address resident preferences and changes to their ability no less than quarterly and PRN. -Facility staff were educated on following dietary recommendations as noted on meal tray cards. -Resident meal preferences, assistance needs and abilities will be assessed quarterly at care conferences. -2-3 Privacy audits including pulling blinds, closing doors, pulling privacy curtains will be completed 2 x times weekly x 3, and weekly thereafter. to be reviewed at QAPI	5/25/17

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F 241	Continued From page 21 and required extensive assistance to dress. The staff was directed to anticipate and meet the resident's needs and to decrease episodes of agitation. NA-L reported on 4/12/17, at 7:35 a.m. she had been a NA for several years. When asked about providing privacy during cares NA-L replied, "Oh sorry," then pulled the privacy curtain shut. NA-L explained the facility's policy and procedure was to provide dignity by pulling the shades and privacy curtain, and ensuring the door was closed. NA-L verified she should have provided privacy for R1 to ensure she was not exposed. R1 was interviewed following the observation and how she felt about not being covered during cares. R1 replied, "It doesn't bother me. This is how they do it everyday. What can I do?" During an interview on 4/12/17, at 1:46 p.m. the executive director (ED) stated he expected staff to provide dignity and privacy to all residents by pulling the curtain and closing the door. The facility's 1/12, Policy on Resident Rights, Respect & Dignity policy and procedure noted "staff are responsible to maintain and enhance residents self-esteem and worth, by providing personal privacy." R49 was observed on 4/11/17, at 8:34 a.m. while seated at a table in the 3N dining room. R49 was served a plate of food with a pancake, a sausage patty and scrambled eggs. R49 ate bites of her scrambled eggs with a spoon, but ate the uncut pancake and uncut sausage patty with her fingers.	F 241	to determine compliance and need to continue. -Dining dignity audits to be completed 2 x weekly, x 3 and weekly thereafter. To be reviewed at QAPI to determine compliance and need to continue. -DON or designee will be responsible for audits. -Date of compliance 5/25/2017.	

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At 8:45 a.m. NA-P sat down at R49's table and helped another resident to eat. No assistance was provided by NA-P or other staff in the room to cut R49's food or encourage her to utilize utensils.

The following morning on 4/12/17, at 8:25 a.m. R49 was observed sitting at the table in the dining room. NA-K set a plate of food in front of R49, and asked if she wanted her french toast and sausage cut, but did not offer to also cut her bacon. R49 replied "yes." The french toast was cut and added maple syrup. NA-K quickly made a couple of cuts into R49's sausage patty and then walked away. Although the patty had cut marks on it, it was not fully cut through or into bite-sized pieces. R49 picked up her fork and stabbed at the patty, and then picked it up with her fingers and pulled off a piece. She picked up a piece of bacon and broke it into pieces.

At 8:34 a.m. NA-P sat down by R49's tablemate. R49 unsuccessfully attempted to cut up her sausage patty up with a fork, and eventually picked up the uncut sausage with her fingers. NA-K asked if she wanted anything more to eat, poured apple juice, and walked away. R49 ate some bites of scrambled eggs and some of the pieces dropped onto the towel covering her clothing. R49 picked up the dropped pieces of egg and placed them on her plate. R49 ate all of the food and beverages served at the meal.

R49's quarterly Minimum Data Set dated 3/1/17, indicated R49 required limited staff assistance for eating, with R49 being highly involved in the activity. Staff provided guidance of maneuvering of limbs or other non-weight bearing assistance.

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F 241	Continued From page 23 R49's current careplan directed staff to assist the resident with meal set-up, cutting food into small pieces, and to provide supervision with all meals. Staff were to provide as much assistance as R49 required at mealtime. On 4/13/17, at 10:33 a.m. the assistant director of nursing (ADON) stated she did not consider eating with fingers to be dignified. The ADON stated staff should have asked R49 if she wanted her food cut up and were expected to follow care plans because that was how the staff knew of how to provide care for their residents. The facility's 1/12, Dignity policy "Staff are responsible for carrying out activities that assist the resident to maintain and enhance each residents self-esteem and self-worth. Examples of dignified care include...Offering assistance when and as needed."	F 241		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights	F 279		5/25/17

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F 279	Continued From page 24 set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record. (iv)In consultation with the resident and the resident’s representative (s)- (A) The resident’s goals for admission and desired outcomes. (B) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 279		

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F 279	Continued From page 25 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a care plan for 1 of 1 residents reviewed (R35) related to pressure ulcers. Findings include: R35's care plan dated 3/21/17, identified that R35 had actual alteration of skin integrity due to being cognitively impaired, assistance with ADLs, neurodermatitis, and had scratches/wounds on both lower extremities, left buttock, shoulder, and chest. R35's care plan directed facility staff to assist with repositioning frequently in bed to avoid laying on open areas. The care plan directed staff to ensure that proper pressure reducing device is in the chair and positioned correctly before transferring R35 to wheelchair. Further, the care plan directed staff to "assist with repositioning in bed to avoid laying on open areas frequently". The care plan did not address R35's suspected deep tissue injury to the left heel, unstageable ulcer to right heel, right inner ankle press ulcer, and right great toe wound. The care plan did not direct facility staff how often R35 needed to be turned/repositioned or what pressure relieving devices were to be in place. R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 had moderate cognitive impairment and had diagnoses including rheumatoid arthritis (known to contribute to pain), dementia and anxiety. R35 required extensive	F 279	Alleged tag could potentially could affect every resident in the facility. -R35 passed away prior to receipt of SOD. -Care plans reviewed on residents with pressure ulcers and are current. -Nursing staff educated on updating alterations in skin care plans timely. -Care plans of 2-3 residents with tissue injury will be audited weekly x 6, then monthly thereafter. -Audits results to review no less than quarterly at QAPI for determination of compliance and need to continue. -DON or designee will be responsible for audits. -Date of compliance 5/25/2017.	

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assistance with activities of daily living (ADLs). R35 did not have any pressure ulcers but was at risk. The MDS indicated a formal assessment tool and a clinical assessment were completed to determine R35's pressure ulcer risk.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations due to: weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. Although a pressure ulcer was not identified on the CAA it was noted R35 was at risk for pressure ulcers due to immobility and incontinence, and required a special mattress or seat cushion to reduce or relieve pressure.

R35 was observed continuously on 4/10/17, from 1:58 p.m. to 4:15 p.m. R35 remained in wheelchair without a change in positioning or assistance offered for at least 2 hours, 17 minutes.

On 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to 3:19 p.m. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes. NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F and NA-E changed the incontinent brief and provided peri-care. NA-F described R35's brief as moderately wet. The DON then assessed the resident's skin condition. The DON described R35's skin as: right upper buttock was open and excoriated from moisture, left ischial tuberosity (hip) was boggy and non-blanchable. The left bottom buttock was reddened but blanched, right ischial tuberosity was blanchable, right lower extremity has sores and scabs which had

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Tegaderm dressings, right medial ankle pressure ulcer and treatment to be done at bedtime. R35's Prevalon boot was soiled with blood and wound drainage which was confirmed by the DON. R35's wheelchair cushion was approximately one half inch in height, and the DON confirmed it "does not feel adequate." NA-F reported she did not know the last time R35 had been changed or repositioned.

The next day on 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON was unaware why care had not provided care for R35. The DON stated R35 sometimes resisted care. The DON stated she felt staffing challenges contributed to issues with timely care for R35. The surveyor informed the DON of serious concerns regarding R35 and she responded, "Me too." The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an assessment of the resident's skin condition. The DON changed the incontinent brief and provided peri-care. The DON did not know the last time R35 was last changed or repositioned.

During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition, as she was unable to move herself.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A reported he had first seen R35 on 4/7/17 and was

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following the right medial ankle and right heel pressure ulcers. MD-A was Dr. was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. It was MD-A's impression the staff were elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks.

NA-A stated on 4/13/17, at 8:17 a.m. R35 was to be checked on every 15-20 minutes. Staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.

On 4/13/17, at 8:28 a.m. LPN-D reported it was expected the NAs would check on the resident because of her skin issues. LPN-D believed the right hip area was due to pressure, and the other wounds were from scratching and picking at herself.

On 4/13/17, at 10:56 a.m. NA-G was unsure if R35 had wounds on her feet, or whether any changes had been made to her care plan in the last week.

However, on 4/13/17, at 11:05 a.m. NA-H reported R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's

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heels or feet.

On 4/13/17, at 12:30 p.m. the DON stated that the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. Prior to the survey entrance the DON said she had not thought of putting a different mattress on R35's bed. The DON expected staff to reposition, check and change R35 at least every two hours. The DON expected nurses to monitor R35's skin every shift and assess once weekly on bath day, and to document findings. In addition, it was expected a comprehensive skin assessment would be completed when a new area was found. The DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated she felt it should have been.

The facility's policy and procedure titled "Repositioning and Turning" which was not dated, indicated "that residents are turned/positioned in accordance with the plan of care to prevent skin breakdown." The policy further indicated that residents who are unable to reposition themselves will be turned and repositioned every one to two hours in accordance with their needs, using a written care plan as determined by licensed staff. The standards of the policy indicated the Charge Nurse was responsible for incorporating the plan, approaches, and goal on the care plan.

A second policy titled Chalet Living and Rehab "Wound Care Program" dated 4/21/14, indicated the Braden Scale had to be completed upon

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F 279	Continued From page 30 resident's admission and weekly for the first 4 weeks of admission to determine the score and the level of risk for skin breakdown. Then, the risk factor(s), potential cause(s) and interventions should be reviewed and addressed on the care plan. The policy indicated when a resident is in bed or wheel chair they should be turned/reposition at least every two hours or as indicated on the resident's care plan. Lastly, the policy stated the care plan shall be evaluated and revised based on the resident's response to treatment, goals, and outcomes.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow careplans for 1 of 1 residents (R22) reviewed for hearing and for 1 of 13 residents (R49) needing meal assistance. In addition, the facility failed to follow a careplan for toileting assistance for 1 of 3 residents (R35) reviewed for activities of daily living (ADLs). Findings include: R22 was not consistently provided his hearing aide. On 4/11/17, at 2:05 p.m. Family Member (FM)-C stated R22 did not have his hearing aide	F 282	All residents requiring assistance with ADL's have the potential to be affected by this. -R35 passed away prior to receiving SOD. -R22 hearing aid has been replaced. -R22 care plan has been reviewed and is current. -R49 care plan does have finger food offered per resident preference. -R49 care plan has been reviewed and is current. -Staff have been educated on following care plans.	5/25/17

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in his ear at 1 p.m. today and stated that the nurse she talked to today had not known that R22 was missing his left hearing aide. FM-C stated R22's left hearing aide had been missing for a few months and that the administrator had stated he would look into it and had not yet gotten back to her.

R22's annual Minimum Data Set (MDS) indicated R22's cognition was moderately impaired, hearing indicated minimal difficulty, and wears hearing aides. R22's same annual MDS indicated R22 makes self understood and understands. The annual MDS also indicated R22 needed staff assistance with dressing and personal hygiene.

R22's 1/31/17, Care Area Assessment indicated R22 has impaired hearing and wears hearing aides.

R22's 3/24/16, careplan indicated "Check for wax in [R22s] ears...Place hearing aids in both ears. Make sure hearing aids are working...clean hearing aids [in the top drawer of med cart] every night shift every Thursday" R22's careplan dated 3/30/17, indicated, "Hearing Aids: Insert Hearing Aids in Both Ears Every Morning"
On 4/11/17, at 2:05 p.m. R22 was observed lying on top of his bed eyes closed with no hearing aides in ears observed.

On 4/11/17, at 2:36 p.m. nursing assistant (NA)-P stated R22 had just come to this unit 2-3 weeks ago and NA-N had gotten R22 up today. NA-P stated R22's hearing aide was kept in the nursing cart.

The following morning at 9:15 a.m. R22 was pushed in his wheelchair (w/c) NA-K up to the

-Audits of 2-3residents requiring assistance with ADL's will be done to determine compliance with care plans 2 x weekly, x3 then weekly thereafter. Audit results to be reviewed at QAPI for determination of compliance and need to continue.
-DON or designee will be responsible for audits.
-Date of compliance 5/25/2017.

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table in the dining room. No hearing aides were observed in R22's ears. R22 started taking a few bites of his french toast and then without trying the bacon, oatmeal and liquids started wheeling himself out of the dining room into the hall next to his room door. Surveyor asked R22 a question and R22 just looked back at surveyor and did not speak. Surveyor asked NA-P if R22 wore hearing aides and NA-P said yes. NA-P then asked R22 if he could hear her and R22 answered "barely". NA-P stated she had not helped R22 up this morning that NA-K had assisted R22. NA-P stated she would tell the nurse R22 did not have his hearing aide in this morning. NA-P wheeled R22 back up to the dining room table and asked him if he wanted juice and poured him a glass and R22 took a drink. Registered nurse (RN)-F brought R22 his hearing aide for his right ear and placed in his ear and resident stated he could now hear. R22 then proceeded to take bites of his food.

Half hour later at 9:34 a.m. RN-F stated R22 had moved up to this unit from another floor and had lost his hearing aide before coming to this unit. RN-F stated R22 now only had one hearing aide and that family was aware.

On 4/12/17, at 10:23 a.m. RN-F stated there was a standing order for ear drops and flushing which was used for R22 in January. RN-F stated she checked residents' ears every three months for wax build up and if wax build up was observed ear drops would be place for three days and then on the fourth day would flush the ears. RN-F verified on R22's treatment administration record (TAR) that ear drops had been administered to R22 on 1/28/17, and 1/30/17, and that on 1/29/17, ear drops were not given as unavailable. RN-F

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also verified that the TAR did not indicate an ear flush to remove wax had been completed. RN-F stated the nurses know that the flush comes after the ear drops on the fourth day. RN-F stated she did not know why the ear drops would have not been available the 2nd day as there was house stock. RN-F verified on R22's physician order that there was an order on 1/27/17, for ear drops to be started for flush could be completed by nurse practitioner (NP) on 1/30/17. RN-F stated the nurse working on 1/30/17, should have placed ear drops for R22 since 1/28/17, had been missed. RN-F stated the NP should have been notified and verified no documentation in the progress notes indicated that the NP had been notified. RN-F stated NP fax their notes to the facility. RN-F stated she would look at R22's ears today and if had wax build up she would follow the standing order and start ear drops for R22 and notify NP and document this in the progress notes. RN-F stated NA-P had told her this morning R22 needed his hearing aide put in but had been busy giving out medications at the time. RN-F stated R22 responded to her when she called him by the name he preferred and not his given name.

On 4/13/17, at 9:57 a.m. R22 was observed lying on top of his bed eyes closed with no hearing aide in right ear.

On 4/13/17, at 10:03 A.M. Social Services Director (SS) stated he was aware of R22's hearing aide missing a couple of weeks ago when FM-C had told him and FM-B had told him that the hearing aide had been missing quite awhile. SS stated he referred FM-C to the administrator but thought licensed social worker (LSW)-A had already done that.

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On 4/13/17, at 11:01 a.m. the assistant director of nursing (ADON) who also was the manager of R22's unit stated she had not been aware of R22's hearing aide not being in his ear and stated it was the nurse's responsibility as the hearing aide was locked in the cart. ADON stated ear drops and flush were a standing order and she expected nursing staff to follow the orders and if for some reason can not complete a treatment should pass on to the next nurse and expected the nurse to complete it. ADON stated R22's ear drops should have been given on the fourth day for not being completed on the second day. ADON also stated the flush should have been written on the TAR and documented in the progress notes that the treatment was completed and the results. ADON stated R22 had come up to her unit from the 2nd floor and had remember talking about his missing hearing aide in an interdisciplinary team meeting. ADON stated the facility had replaced another resident's hearing aides last fall because of new regulations. ADON stated discussion had been about if resident puts in the hearing aide in or if the staff does or staff drops them. ADON stated nurses should put in residents' hearing aides in at 8 a.m. or upon getting up. ADON stated it would benefit the residents to have the hearing aides in. ADON stated she had talked to FM-C about a week ago and she had not mentioned to her about staff not putting in R22's hearings aides.

Nursing Progress Note dated 3/15/17, indicated, "Resident had none of the hearing aids in this evening, Resident not able to articulate the whereabouts of the hearing aids. writer searched in the room and unable to relocate them."

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Review of NP's January 2017 notes did not indicate an ear flush had been completed for R22. NP note dated 3/14/17, indicated "HL [hearing loss], bilateral [R22] Wears bilateral hearing aids. Was only wearing one today during visit."

R22's nursing progress note dated 4/12/17, written by RN-F indicated R22's ears were inspected for ear wax with wax built up in the right ear and started ear drops for right ear for three days and irrigation of ear to follow on the fourth day.

On 4/13/17, at 2:22 p.m. director of nursing (DON) stated R22's family had asked her to clean out R22's ears and she had asked the NP to do this and to her knowledge thought it had been done. DON stated it should be documented in the NP notes. DON stated the family was not happy with the 3N unit since R22 being recently moved up there and stated she would be doing some education the staff the importance of hearing aid placement as since if you can not hear you would be upset. DON stated the hearing aids should be provided in morning cares and no later than when residents come out to breakfast.

R49 was observed on 4/11/17, at 8:34 a.m. sitting at a table in the 3N dining room. Couple minutes later R49 was served a plate of food on the table. R49's plate had a pancake, a sausage patty and scrambled eggs. R49 proceeded to take bites of her scrambled eggs with a spoon in her right hand. R49 picked up her uncut pancake and proceeded to take bites of her pancake with her fingers and then picked up her uncut sausage patty with her hands and take bites of the sausage patty with her fingers.

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At 8:45 a.m. NA-P sat down at R49's table and helped another resident to eat. No assistance was provided to R49. Staff was present in the dining room and did not offer to assist R49.

The following morning on 4/12/17, at 8:25 a.m. R49 was observed sitting at the table in the dining room on 3N. A couple minutes later NA-K set a plate of food in front of R49 on the table. NA-K cut up R49's french toast and poured maple syrup. NA-K quickly cut couple times into the sausage patty without cutting through into smaller sections and walked away from table. The sausage patty was observed to have two marks in it but not cut apart. R49 picked up her fork in her right hand stabbing at the sausage patty and then unable to cut apart picked up the sausage patty with her left hand and pulled off a piece and put in her mouth. R49 holding bacon with left hand and fork in right hand breaking bacon into pieces. NA-K had not asked R49 if she wanted her bacon cut up into smaller pieces, only asked her about the sausage and french toast which she said yes she would like cut up.

At 8:34 a.m. NA-P sat down by another resident at the same table where R49 sat. R49 then proceeded to attempt to cut up her sausage patty up with her fork and after many attempts picked up the sausage with her left hand and took bites of. NA-K walked up to R49 and asked if R49 wanted anything more to eat and NA-K proceeded to pour apple juice and then walked away. R49 took some bites with fork in her right hand of scrambled eggs and dropped some pieces of egg on her towel and picked up pieces and set down on plate. R49 ate all her food and beverages.

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R49's quarterly Minimum Data Set dated 3/1/17, indicated R49 needed limited staff assistance for eating and also indicating R49 was highly involved in activity and staff provided guidance of maneuvering of limbs or other non wt-bearing assistance.

R49's current careplan indicated staff were to assist for meal set-up, cut food into small pieces, and provide supervision with all meals. The same careplan also indicated staff were to provide as much assistance as needed with meals.

On 4/13/17, at 10:33 a.m. the assistant director of nursing (ADON) stated she did not consider eating with fingers dignified. ADON stated staff should have asked R49 if she wanted her food cut up and staff were expected to follow careplans because that is how the staff know of how to provide care for their residents.

Policy provided by the facility Care Plans dated July 2015, indicated "... Reflects the resident/resident representative input and goals for healthcare"
R35 was not offered toileting assistance according to her plan of care. R35's care plan dated 3/21/17, identified R35 needed assist of two staff members for toileting. R35 was to be checked at least every two hours for incontinence. The care plan directed staff to monitor for signs of incontinence decline and to offer/encourage the toilet upon rising, before and/or after meals, and at bedtime and during night rounds. Further, the care plan directed staff to assist with perineal hygiene after toileting, change incontinent briefs when soiled and to check brief for incontinence with rounding.

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R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 required extensive assistance with activities of daily living (ADLs). R35 was not on a toileting program, however, was frequently incontinent of bladder and bowel. R35's Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs. The CAA further identified R35 had chronic health issues/conditions, such as incontinence or pain that resulted in reduced activity participation. The CAA identified that R35 had urinary urgency and needed assistance in toileting which contributed to incontinence. The CAA also identified that R35 was offered toileting upon rising, after meals, at bedtime, and on rounds. R35 wore an incontinence brief to protect her skin and provide dignity.

R35 was continuously observed on 4/10/17, from 1:58 p.m. to 4:15 p.m. At 4:15 p.m. R35 remained in wheelchair without a change in positioning or assistance offered for at least 2 hours, 17 minutes.
On 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to 3:19 p.m. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes. NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F described R35's brief as moderately wet. NA-F and NA-E changed R35's pants, as the ones she had been wearing were wet wet with urine. R35's wheelchair cushion was saturated with a circular area of urine and smelled strongly of urine. NA-F confirmed the cushion was wet with urine, and attempted to clean it with a Sani Wipe. NA-F reported she did not know the last time R35 had been changed or repositioned.

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F 282	Continued From page 39 On 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. The room had a strong urine odor. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON was unaware why care had not provided care for R35. The DON stated she felt staffing challenges contributed to the issues with timely care for R35. The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and changed the incontinent brief and provided peri-care. The DON described R35's brief as saturated with dark colored pungent smelling urine. The DON did not know the last time R35 was last changed or repositioned. The DON expected staff to follow the care plan and to change and reposition R35 at least every two hours. On 4/11/17, at 3:20 p.m. NA-F explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition, as she was unable to move herself. NA-F stated R35 requested to use the toilet at times, but was unable to bear weight, therefore, her incontinence brief was changed in bed. On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A who reported he had first seen R35 on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A stated he expected the resident would be repositioned out of her wheelchair at least every two hours. NA-A stated on 4/13/17, at 8:17 a.m. staff was supposed to check on R35 every 15-20 minutes.	F 282		

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F 282	Continued From page 40 NA-A was unaware if there had been changes to R35's care plan. On 4/13/17, at 10:56 a.m. NA-G stated she had repositioned and changed R35's wet incontinence brief at 7:00 a.m. NA-G stated the night shift had changed R35 at 5:00 a.m. R35 stayed in bed after incontinence care, and was reapproached at 10:00 a.m. and 10:35 a.m. to offer repositioning, but said R35 had refused. However, on 4/13/17, at 11:05 a.m. NA-H reported she had changed R35's incontinence brief at 7:30 a.m. and the resident had been incontinent of both bowel and bladder. NA-H was unsure when R35 had been changed prior to that time. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. On 4/13/17, at 12:30 p.m. the DON stated the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON expected staff to reposition, check and change R35 at least every two hours. The care tracker was a tool for NAs to use to know R35's plan of care which indicated R35 was continent of bowel. The care tracker directed staff to monitor for urgency and give suitable time in the bathroom. R35 was frequently incontinent of bladder and to offer toileting with rounds. Staff was directed to offer/encourage to use toilet upon rising, before and/or after meals at bedtime and during night rounds.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		5/25/17

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F 309	Continued From page 41 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate pain management for 2 of 4 residents (R35, R73)	F 309	This deficiency has the potential to affect any resident has pain. -R35 has passed away prior to receiving	

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reviewed with pain.

Findings include:

R35 was observed continuously on 4/11/17, from 12:30 p.m. to 3:19 p.m. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes. NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F and NA-E assisted R35 to transfer to bed. When seated on the edge of the bed R35 stated. "God almighty! Help me! I'm leaning way over." NA-F lifted R35's legs into bed and R35 stated, "Ow."

On 4/11/17 at 3:45 p.m., licensed practical nurse (LPN)-C and LPN-B were observed to complete a right ankle dressing change for R35. LPN-C removed R35's right sock and reported there was a sore on her great right toe, not previously identified. LPN-C stated the ankle dressing being removed was dated 4/9/17 (two days prior). LPN-C reported no Allevyn was present on the ankle. R35 complained of pain when the dressing was removed. As LPN-C cleansed the wound with normal saline R35 screamed out, "That hurts!" LPN-B applied Santyl to entire wound bed and edges covered with Allevyn, wrapped with Kerlix, and dated the dressing.

On 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. At 10:10 a.m. the surveyor informed the DON of serious concerns regarding R35's lack of timely services and pain management and she responded, "Me too." The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an

F 309

SOD
-R73 was interviewed and stated "he was ok waiting for medications" he had no adverse effects from the delay.
-Prior to survey exit two sets of backup keys for medication carts were obtained.
-Staff have been educated on medications available in the Omni cell and process to obtain medication from Omni cell.
-Staff educated on alternative pain control methods.
-Staff educated on process for lost or missing med cart keys.
-Audit of at least 2-3 residents(at risk for pain or requesting prn pain medication)will be completed to determine timely compliance 2X weekly X3 then weekly, to be brought to QAPI for determination of compliance and need to continue.
-DON or Designee will be responsible for audits.
-Date of compliance May 25, 2017

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assessment of the resident's skin condition. The DON changed the incontinent brief and provided peri-care. The DON then assessed the resident's skin condition and reported R35's left heel was lying directly onto the bed. R35 moaned in pain and stated she "hurts everywhere" when assisted to turn to her right side. R35 moaned, tightened her jaw and had furrowed brows when assisted to turn to her left side. The DON observed the left heel, which she stated was a suspected deep tissue injury measuring 1 cm x 1 cm x 1 cm. R35 reported the area was painful to touch. The DON put the gripper sock back onto the resident's left foot, which was directly on the mattress without a pressure reliving device in place. The DON confirmed she was aware of the status of R35's left heel last week, but did not know the severity of the wound and had not assessed it herself.

R35's annual Minimum Data Set (MDS) dated 2/7/17, indicated R35 had moderate cognitive impairment and had diagnoses including rheumatoid arthritis (known to contribute to pain), dementia and anxiety. In addition, the MDS indicated R35 required extensive assistance with activities of daily living (ADLs). Although pain was not identified on the annual MDS, R35 was noted to have a scheduled pain medication regimen. However, R35 had not been observed to be offered the as needed (PRN) medications or non-pharmacologic interventions for pain management prior to her dressing changes.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations due to pain. The CAA further identified R35 had chronic health issues/conditions, such as incontinence or pain that resulted in reduced

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activity participation.

R35's care plan dated 3/21/17, identified pain episodes due to rheumatoid arthritis, history of left knee pain, shoulder and generalized pain. R35's care plan directed facility staff to monitor/document/report to MD PRN any signs/symptoms of pain after exercise or weight bearing. The care plan further directed staff to anticipate need for pain relief, respond immediately to any complaint of pain, and to monitor/record pain characteristics. R35's care plan further directed staff to monitor for effectiveness of pain medication with follow through if ineffective, monitor/record/report to nurse any signs/symptoms of non-verbal pain, and "keep pain free and comfortable."

During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition. NA-F stated R35 requested to use the toilet at times, but was unable to bear weight, therefore, her incontinence brief was changed in bed. NA-F denied being aware of open areas on R35's buttocks, but had noticed red/yellow drainage from her right ankle on the bed sheet. NA-F stated R35 frequently complained of pain during the night.

On 4/12/17, at 9:14 a.m. trained medication aide (TMA)-D stated R35 yelled when staff was not responding to her requests for help. R35 received Tylenol for pain when she got up for the day, but usually not until 10:00 a.m. or 11:00 a.m.

NA-A stated on 4/13/17, at 8:17 a.m. R35 "always says she is in pain" and was "cussing when

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getting dressed and putting her in the wheelchair." R35 complained of pain in her feet and legs. NA-A stated they are supposed to check on R35 every 15-20 minutes. NA-A confirmed staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began.

On 4/13/17, at 11:05 a.m. NA-H stated she was aware R35 had wounds on her thighs, toe, ankle, and heel and that R35 had "a lot of pain" and would not let NA-H touch her right leg due to the pain. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch.

An interview was conducted with LPN-A via telephone on 4/13/17, at 11:12 a.m. LPN-A explained he had been the only nurse on the floor on 4/10/17, and "it was busy and difficult to get things done." LPN-A stated R35 was often "in pain and every part of her body is sore."

On 4/13/17, at 12:30 p.m. the DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but stated she felt it should be.

R35's progress notes from 3/6/17, to 4/11/17, identified on 3/6/17, R35's right inner malleolus was painful to touch and tender.

R35's physician orders included acetaminophen (Tylenol) 1000 milligrams (mg) by mouth twice daily for pain and once daily as needed (PRN).

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Pain assessments dated 2/1/17 to 4/12/17, indicated an increase frequency and severity (1-10, with 10 being the most severe pain) of pain. In 2/17, R35 had pain two days rated at a 4 and 5. In 3/17, R35 had pain eight days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 2, 4, and 5. Facility documentation for nursing assistants indicated R35 could be aggressive when in pain and exhibited agitation with pain.

The facility policy and procedure titled "Pain Management and Assessment" dated 7/28/15, indicated residents would receive the necessary comfort to perform activities of daily living.
R73 informed the surveyor on 4/11/17, at 1:24 p.m. he had been in pain for the last hour and requested his oxycodone-acetaminophen (combination opioid narcotic and non-opioid pain reliever for moderate to severe pain). R73 explained he was experiencing 8 out of 10 pain (10 being the worst possible pain) in his right shoulder and lower back. R73 reported when he had requested pain medication from the nurse, and he had been told he would have to wait because the keys to the narcotic box were missing.

R73's care plan dated 11/30/16, indicated R73 made his own decisions and had chronic pain in his right shoulder and back. R73's goal was to have pain controlled. Interventions included providing medication as ordered, monitoring causes of pain and notify nursing. R73's medication administration record (MAR) for 4/17, indicated he was to receive oxycodone-acetaminophen 5-325 milligrams (mg)

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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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1 tablet every four hours for pain rated 1-6 or 2 tablets for pain rated 6-10. The last time R73 had been administered the medication was on 4/10/17, at 4:12 p.m.

On 4/11/17, at 1:30 p.m. RN-A explained he had misplaced the only set of keys that opened the narcotic box where R73's pain medication was kept. RN-A verified R73 had requested oxycodone-acetaminophen over an hour ago, but RN-A had still not found the keys and was still looking for them. The surveyor inquired as to what he planned to do regarding R73's pain management RN-A replied, "I know [R73] well enough that he can wait for his pain medication." RN-A stated he had informed the DON the keys were missing. At 1:37 p.m., after the keys were located, RN-A administered 2 tablets of oxycodone-acetaminophen to R73.

On 4/11/17, at 2:01 p.m. the executive director (ED) stated she would have expected the staff to care for residents' needs. "No resident should go in pain for over an hour and all residents should get their pain medication when they ask for it or provide another form of pain relief if appropriate." The ED was unsure if the facility had a second set of keys and would check with the maintenance director.

During an interview on 4/11/17, at 3:56 p.m. the DON explained RN-A asked whether she had picked up his medication cart keys by accident, because they were missing. The DON stated she was aware the keys were only missing a few minutes, as she had received a text a few minutes later that the keys had been located. The DON verified the facility did not have a back up set of keys to the narcotic box if the keys went

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F 309	Continued From page 48 missing. The DON said R73 should not have had to wait over an hour to get his pain medication. Instead, the RN should have called the pharmacist to obtain permission to take the needed medication from the Omnicell (medication storage system) or provided R73 with acetaminophen. In addition, the DON verified RN-A should have contacted her immediately when he noticed the keys were missing. The facility's 7/28/15, Pain Management and Assessment policy and procedure indicated residents would receive necessary comfort to perform activities of daily living.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely toileting services were provided for 1 of 1 residents reviewed (R35) who was completely dependent on staff for checking and changing. Findings include: R35 was continuously observed on 4/10/17, from 1:58 p.m. to 4:15 p.m. At 1:58 p.m. R35 was seated in a wheelchair near the nurses' station with her head lowered in a chin to chest position and her eyes closed. The resident was wearing a Prevalon boot (soft blue boot used to aid in pressure relief) on her right foot. At 2:30 p.m. R35	F 312	The alleged tag has the potential to affect all residents in toileting. -R35 passed away prior to receiving SOD. -Care plans of residents needing toileting assistance have been reviewed and are current. -Policy on ADL's has been reviewed and is current. -Staff educated on policy of toileting dependent residents. -Hand off report for shift change is being used by aids/nurses. -Toileting audit of 2-3 residents will be completed 2 x weekly, x 3 and one time weekly thereafter. Will be reviewed at	5/25/17

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remained in the same position; at 3:15 p.m. a nursing assistant (NA) walked by R35 but did not offer cares. At 3:50 p.m. R35 remained in the same position when the director of nursing (DON) walked past the resident. At 4:15 p.m. R35 remained in wheelchair without a change in positioning or assistance offered for at least 2 hours, 17 minutes.

The following day on 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to 3:19 p.m. R35 was seated in a wheelchair without being offered or assisted to reposition or toilet. At 12:30 p.m. while at the dining room table, her eyes were closed and she leaned to the right side. R35 was wearing the Prevalon boot on the right foot and a gripper sock on the left with both feet touching the floor. R35 remained in same position with no offers for cares or repositioning until 2:08 p.m. when R35 called out, "Is anyone around? I'm ready to go to bed." No staff were present in the dining room. R35 then yelled, "Can I have some water?" Nurse consultant (NC)-F entered the dining room and provided R35 a glass of water and then left the room. At 2:22 p.m. NA-A asked R35 if she wanted to go sit by the nursing station which was declined. NA-A offered water and was declined. NA-A locked R35's right wheelchair brake and walked away. R35 yelled out "What time is it?" NA-A replied from the nursing station, "It's 2:25 in the afternoon." R35 again asked the time, and NA-A went to the resident to inform her of the time and ask if she wanted to sit by nurses' station. No cares were offered nor was the resident assisted with any cares. At 2:57 p.m. residents began gathering in the dining room for an activity. R35 remained at the table in the dining room with her head to her head to chest,

QAPI for determination of compliance and need to continue.
-DON or designee will be responsible for audits.
-Date of compliance 5/25/2017.

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eyes closed, and leaning to the right side. Life enrichment coordinator (LEC)-A moved R35's wheelchair slightly forward to accommodate another resident. At 3:01 p.m. licensed social worker (LSW)- B entered the dining room and left without offering assistance to R35. Housekeeper (HK)-A then asked R35, "You done eating?" R35 responded, "Yes." HK-A walked away to another table and left R35's food in front of her. At 3:06 p.m. R35's tray was removed, but no other cares were offered. At 3:19 p.m. NA-F assisted R35 out of the dining room and informed her she would help change her incontinence brief. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes.

NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F and NA-E assisted R35 to transfer to bed. When seated on the edge of the bed R35 stated. "God almighty! Help me! I'm leaning way over." NA-F lifted R35's legs into bed and R35 state, "Ow." NA-F and NA-E removed the Prevalon boot, changed the incontinent brief and provided peri-care. NA-F described R35's brief as moderately wet. The DON then assessed the resident's skin condition. The DON stated R35's skin condition as: right upper buttock was open and excoriated from moisture, the left ischial tuberosity (hip) was boggy and non-blanchable. The left bottom buttock was reddened but blanched, right ischial tuberosity was blanchable, the right lower extremity had sores and scabs which had Tegaderm dressings, and the right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON confirmed was soiled with blood and wound drainage. NA-F and NA-E changed R35's pants,

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as the ones she had been wearing were wet wet with urine. R35's wheelchair cushion was saturated with a circular area of urine and smelled strongly of urine. NA-F confirmed the cushion was wet with urine, and attempted to clean it with a Sani Wipe. NA-F reported she did not know the last time R35 had been changed or repositioned. R35 requested to get up again, and was assisted back into her wheelchair.

After the NAs and the DON left the room, licensed practical nurse (LPN)-C and LPN-B entered at 3:45 p.m. to complete a right ankle dressing change. LPN-C removed R35's right sock and reported there was a sore on her great right toe, not previously observed. The soiled dressing was Kerlix and gauze that was saturated with foul smelling yellow/blood-tinged drainage. LPN-C described the wound as "reddened with discoloration on the edges" and measured 5 centimeters (cm) x 4 cm x 1.5 cm.

On 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. At 7:03 a.m. R35 was resting in bed with her eyes closed, slightly tilted to her right side. The room had a strong urine odor. R35 continued in the same position until at 9:53 a.m. NC-F stopped at R35's door, looked in and continued to walk past the room. At 10:02 a.m. the surveyor attempted to locate an available staff person to intervene. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON was unaware why care had not provided care for R35. The DON stated R35 sometimes resisted care. The DON stated she felt staffing challenges contribute to timely care for R35. The

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DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an assessment of the resident's skin condition. The DON changed the incontinent brief and provided peri-care. The DON described R35's brief as saturated with dark colored pungent smelling urine. The DON did not know the last time R35 was last changed or repositioned. The DON expected staff to follow the care plan and to change and reposition R35 at least every two hours.

R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 had moderate cognitive impairment and had diagnoses including rheumatoid arthritis (known to contribute to pain), dementia and anxiety. R35 required extensive assistance with activities of daily living (ADLs). R35 was not on a toileting program, however, was frequently incontinent of bladder and bowel.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations due to: weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. The CAA further identified R35 had chronic health issues/conditions, such as incontinence or pain that resulted in reduced activity participation. The CAA identified that R35 had urinary urgency and needed assistance in toileting which contributed to incontinence. The CAA also identified that R35 was offered toileting upon rising, after meals, at bedtime, and on rounds. R35 wore an incontinence brief to protect her skin and provide dignity.

R35's care plan dated 3/21/17, identified R35 needed assist of two staff members for toileting. R35 was to be checked at least every two hours

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for incontinence. The care plan directed staff to monitor for signs of incontinence decline and to offer/encourage the toilet upon rising, before and/or after meals, and at bedtime and during night rounds. Further, the care plan directed staff to assist with perineal hygiene after toileting, change incontinent briefs when soiled and to check brief for incontinence with rounding.

On 4/11/17, at 3:20 p.m. NA-F explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition, as she was unable to move herself. NA-F stated R35 requested to use the toilet at times, but was unable to bear weight, therefore, her incontinence brief was changed in bed. NA-F denied being aware of open areas on R35's buttocks, but had noticed red/yellow drainage from her right ankle on the bed sheet. NA-F stated R35 frequently complained of pain during the night.

On 4/12/17, at 9:14 a.m. trained medication aide (TMA)-D said the reason R35 yelled was when staff was not responding to her requests for help. R35 received Tylenol for pain when she got up for the day, but not usually until 10:00 a.m. or 11:00 a.m.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A reported he had first seen R35 on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was Dr. was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. It was MD-A's impression the staff was elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be

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repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks.

NA-A stated on 4/13/17, at 8:17 a.m. staff was supposed to check on R35 every 15-20 minutes. Staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.

On 4/13/17, at 10:56 a.m. NA-G stated she had repositioned and changed R35's wet incontinence brief at 7:00 a.m. NA-G stated the night shift had changed R35 at 5:00 a.m. NA-G reported R35 "screamed in pain" when assisted to reposition. R35 stayed in bed after incontinence care, and was reapproached at 10:00 a.m. and 10:35 a.m. to offer repositioning, but said R35 had refused.

However, on 4/13/17, at 11:05 a.m. NA-H reported she had changed R35's incontinence brief at 7:30 a.m. and the resident had been incontinent of both bowel and bladder. NA-H was unsure when R35 had been changed prior to that time. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's heels or feet.

On 4/13/17, at 12:30 p.m. the DON stated the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving

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F 312	Continued From page 55 interventions noted on the care plan. The DON expected staff to reposition, check and change R35 at least every two hours. The care tracker was a tool for NAs to use to know R35's plan of care which indicated R35 was continent of bowel. The care tracker directed staff to monitor for urgency and give suitable time in the bathroom. R35 was frequently incontinent of bladder and to offer toileting with rounds. Staff was directed to offer/encourage to use toilet upon rising, before and/or after meals at bedtime and during night rounds.	F 312		
F 313 SS=D	483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assist with hearing aid placement, to communicate a decision regarding a lost hearing aid, and to ensure treatment to promote optimal hearing for 1 of 1 resident (R22) reviewed for hearing.	F 313	This tag could potentially affect any resident that is hearing impaired. -R22 hearing aid has been replaced. -R22 care plan has been reviewed and is current. -Training on placement and compliance with hearing aids completed with staff.	5/25/17

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F 313	Continued From page 56 Findings include: R22's family member (FM)-C reported on 4/11/17, at 10:15 a.m. did not always clean out R22's ears. FM-C wanted R22's ear to be cleaned "at least periodically." FM-A explained R22 had new stronger hearing aids purchased just last year, but one had been lost at the facility "awhile ago." FM-C reportedly was waiting for a decision from the administrator as to whether the facility planned to replace it. In addition, FM-C said often staff had not put R22's hearing aid in, which meant R22 could not hear when FM-C tried to visit with the resident. On 4/11/17, at 2:05 p.m. FM-B reported R22 did not have his hearing aid in at 1:00 p.m. that day. The nurse FM-B had talked to that day was unaware R22 was missing his left hearing aid. FM-B explained the left hearing aid had been missing for a few months. Although the administrator said he would look into the situation, she had not heard back. The following morning at 9:15 a.m. R22 was assisted to the table for breakfast by NA-K. R22 was not wearing hearing aids. R22 ate a few bites of french toast and then without trying the bacon, oatmeal and liquids started wheeling himself out of the dining room into the hallway. The surveyor asked R22 a question, but the resident just looked at the surveyor and did not answer. NA-P confirmed R22 wore hearing aids. NA-P then asked R22 if he could hear her and he answered, "barely." NA-P stated she had not helped R22 up that's morning but NA-K had. NA-P said she would inform the ruse was not wearing his hearing aid in at breakfast. NA-P assisted R22 back into the dining room and offered him juice.	F 313	-Hearing aid placement audits on 1-2 residents requiring assistance with hearing aids will be done 2 x weekly, 3 weekly then one time weekly thereafter until reviewed at QAPI for determination of compliance and need to continue. -DON or designee responsible for audits. -Date of compliance 5/25/2017.	

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Registered nurse (RN)-F then brought R22 his hearing aid and placed it in his right hear. R22 confirmed he could hear and proceeded to eat his breakfast.

On 4/11/17, at 2:05 p.m. R22 was observed lying on top of his bed eyes closed with no hearing aid was observed in his ear. At 2:36 p.m. nursing assistant (NA)-P stated R22 had just moved to the current unit two or three weeks prior. NA-N had assisted R22 to get up that morning. NA-K said R22's hearing aid was kept in the nursing cart.

R22's 1/31/17, Minimum Data Set (MDS) indicated R22 had moderately impaired cognition, wore hearing aids and heard with minimal difficulty. R22 also made himself understood and understood others. R22 required staff's assistance to dress and perform personal hygiene. R22's 1/31/17, corresponding Care Area Assessment indicated R22 had impaired hearing and wore hearing aids.

R22's 3/24/16, care plan directed staff to "Check for wax in ears...Place hearing aids in both ears. Make sure hearing aids are working...clean hearing aids [in the top drawer of medication cart] every night shift every Thursday." R22's careplan dated 3/30/17, indicated, "Hearing Aids: Insert Hearing Aids in Both Ears Every Morning."

RN-F explained on 4/12/16, at 9:34 a.m. R22 had moved up to the unit from another unit, and his hearing aid had been missing prior to the move. RN-F stated R22 now only had one hearing aid and his family was aware the aid was missing. At 10:23 a.m. RN-F explained there had been a standing order for ear drops and flushing used for

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F 313	Continued From page 58 R22 in 1/17. RN-F stated she checked residents' ears every three months for wax build up and if necessary, ear drops would be instilled to soften the wax for three days, and then on the fourth day the ears would be flushed of wax. RN-F verified on R22's treatment administration record (TAR) ear drops had been administered to R22 on 1/28/17 and 1/30/17, but on 1/29/17, it was noted the ear drops were not given as they were unavailable. RN-F also verified that the TAR did not indicate the drops were followed by an ear flush to remove wax. RN-F stated the nurses knew that the flush was to be performed on the fourth day following the ear drops. RN-F was unsure why the drops would have been unavailable on the second day, as there was house stock. RN-F verified on R22's physician's orders there was an order dated 1/27/17, for ear drops to be started and a flush would then be completed by the nurse practitioner (NP) on 1/30/17. RN-F stated the nurse working on 1/30/17, should have placed ear drops in R22's ears, since one day was missed. RN-F stated the NP should have been notified, and verified no documentation was available in the progress notes indicating the NP had been notified. RN-F reported she would examine R22's ears that day and if there was wax build up, she would follow standing orders to start the drops again and then notify the NP and document in the resident's progress notes. RN-F explained that NA-P had told her that morning R22 needed his hearing aid put in, but had been busy administering medications at the time. RN-F stated R22 responded to her when called by name. On 4/13/17, at 9:57 a.m. R22 was observed lying on top of his bed eyes closed with no hearing aid in his right ear.	F 313		

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On 4/13/17, at 10:03 a.m. the social services director stated FM-C had informed him a couple of weeks prior R22's hearing aid had been missing for quite a while. The director said he had referred FM-C to the administrator, but thought licensed social worker (LSW)-A had already informed the administrator of the situation.

On 4/13/17, at 11:01 a.m. the assistant director of nursing (ADON) who also was the manager of R22's unit stated she was unaware R22's hearing aid had not been in, and said it was the nurse's responsibility, as the hearing aid was locked in the medication cart. The ADON stated ear drops and flushes were noted on residents' standing orders, and the nurses were expected to complete the treatments, and if it was not possible to do so, should have then passed it on the other oncoming nurse. The ADON stated R22's ear drops should have been given on the fourth day for not being completed on the second day. Notes about completion and the results of the flushes were to be recorded on the TAR and progress notes. The ADON stated when R22 was transferred from the other unit, she had recalled discussing the missing hearing aid in an interdisciplinary team meeting. Discussion took place regarding who was responsible if the staff put in the hearing aids or the resident did, and if staff dropped them, etc. The ADON stated nurses should have been putting in residents' hearing aids at 8:00 a.m. or when they got up for the day, and would benefit the resident to wear the aids. The ADON reportedly talked to FM-BC about a week prior and she had not mentioned the hearing aids not being provided for R22 by staff.

The NP's 1/17, progress notes did not include

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F 313	Continued From page 60 information indicating an ear flush had been completed for R22. A NP note dated 3/14/17, indicated "HL [hearing loss], bilateral [R22] Wears bilateral hearing aids. Was only wearing one today during visit." Nursing Progress Note dated 3/15/17, indicated, "Resident had none of the hearing aids in this evening. Resident not able to articulate the whereabouts of the hearing aids. Writer searched in the room and unable to relocate them." R22's nursing progress note dated 4/12/17, written by RN-F indicated R22's ears were inspected for ear wax with wax built up in the right ear and started ear drops for right ear for three days and irrigation of ear to follow on the fourth day. On 4/13/17, at 2:22 p.m. the director of nursing (DON) stated R22's family had asked her to clean out R22's ears. She had requested the NP take care of it, and thought it had been completed. The DON stated it should have been documented in the NP's notes. The DON stated the family was unhappy with R22's new unit since the transfer. The DON said she planned to provide some education for the staff regarding the importance of hearing aid placement, and added, "...since if you cannot hear you would be upset." The DON stated the hearing aids should have been provided during morning cares, but no later than when the resident came out for breakfast.	F 313		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity -	F 314		5/25/17

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F 314	Continued From page 61 (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assessment, monitoring and interventions were implemented in a timely manner for 1 of 1 resident (R35) reviewed with pressure ulcers. R35 suffered actual harm, deterioration of pressure ulcers and development of new pressure related breakdown. Findings include: R35 was observed continuously on 4/10/17, from 1:58 p.m. to 4:15 p.m. At 1:58 p.m. R35 was seated in a wheelchair near the nurses' station with her head lowered in a chin to chest position with her eyes closed. The resident was wearing a Prevalon (soft blue boot used to aid in pressure relief) on her right foot. The resident remained in the same position throughout the observation. At 3:15 p.m., nursing assistant (NA)-A walked by the resident. At 3:50 p.m., the director of nursing (DON) walked by the resident. No staff were observed to offer repositioning or any other	F 314	This has the potential to affect all resident -R35 passed away prior to receipt of SOD -Residents with pressure injuries were assessed and current interventions are as per care plan and MD/NP order. MD/NP have been updated on current status of all pressure injuries. - Careplan of residents with pressure ulcers have been reviewed and are current. -Policy on wound management has been reviewed and is current. -Staff educated on policy of weekly skin assessments and wound documentation including measurements, drainage, odor, pain and current treatment as well as notification of MD/NP and resident/and or alternative decision maker for any worsening or non-healing wounds. Staff will continue to be trained over next 3 months on this topic for continued	

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F 314	Continued From page 62 assistance throughout the 2 hour and 17 minute continuous observation. On 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to 3:19 p.m. R35 was seated in a wheelchair without being offered or assisted to reposition or toilet. At 12:30 p.m. approximately half of R35's meal remained, her eyes were closed and she leaned to the right side. R35 was wearing a Prevalon boot on the right foot, had a gripper sock on the left foot, and both feet were resting on the floor. R35 remained in the same position with no repositioning until 2:08 p.m. when R35 called out, "Is anyone around? I'm ready to go to bed." No staff were present in the dining room. R35 then yelled, "Can I have some water?" Nurse consultant (NC)-F entered the dining room and provided R35 a glass of water and left the room. At 2:22 p.m. NA-A asked R35 if she wanted to go sit by the nursing station, and R35 declined. NA-A also offered R35 a drink of water which the resident also declined. NA-A locked R35's right wheelchair brake and walked away. R35 yelled out "What time is it?" NA-A replied from the nursing station, "It's 2:25 in the afternoon." R35 again asked the time, and NA-A went to the resident to inform the resident of the time and asked her if she wanted to sit by the nurses' station. However no cares were offered. At 2:57 p.m. residents began gathering in the dining room for an activity. R35 remained at the table in the dining room with her head to her chin, eyes closed, and she was leaning to her right side. The facility's life enrichment coordinator (LEC)-A moved R35's wheelchair forward slightly to accommodate another resident. At 3:01 p.m. licensed social worker (LSW)- B entered the room and left without offering assistance to R35.	F 314	adherence and education. -An audit tool has been developed to ensure proper documentation and treatment of wounds as well as notification of appropriate parties and to ensure proper care is delivered to meet the needs of those at risk for pressures sores. These audits will be completed on all residents with pressure injuries and as well a sample of those high risk residents weekly and will continue for the next 6 months. The results will be reviewed at QAPI for determination of compliance need to continue. - DON or designee will be responsible for compliance - Date of compliance 5/25/17	

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Housekeeper (HK)-A then asked R35, "You done eating?" R35 responded, "Yes." HK-A walked away to another table and left R35's food in front of her. At 3:06 p.m. R35's tray was removed, but no other care was offered. At 3:19 p.m., 2 hours and 49 minutes after the continuous observation had started, NA-F assisted R35 out of the dining room and informed her she would help change her incontinence brief.

On 4/11/17 at 3:20 p.m., NA-F, the DON and NA-E, entered R35's room to help with her care. NA-F and NA-E assisted R35 to transfer to bed. When seated on the edge of the bed R35 stated, "God almighty! Help me! I'm leaning way over." NA-F lifted R35's legs into bed and R35 stated, "Ow." NA-F and NA-E removed the Prevalon boot, changed the incontinent brief and provided peri-care. NA-F described R35's brief as "moderately wet". However, when NA-F and NA-E changed R35's incontinent brief, they also changed her slacks because the slacks she'd been wearing were wet with urine. In addition, R35's wheelchair cushion was saturated with a circular area of urine and smelled strongly of urine. NA-F confirmed the cushion was wet with urine, and attempted to clean it with a Sani Wipe. The DON then assessed the resident's skin condition. The DON described R35's skin: right upper buttock- open and excoriated from moisture; left ischial tuberosity- boggy and non-blanchable; left lower buttock- reddened but blanches; right ischial tuberosity- blanchable; right lower extremity-sores and scabs which have Tegaderm dressings on them; right medial ankle- pressure ulcer with treatment scheduled for bedtime. R35's Prevalon boot was observed on the bed which the DON verified was soiled with blood and wound drainage. R35's wheelchair

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cushion was noted to be only about one half inch in thick and the DON stated, "it does not feel adequate." During the observation, NA-F reported she did not know the last time R35 had been changed or repositioned. After the care, R35 requested to get up again, and was assisted back into her wheelchair.

After the NAs and DON left the room, licensed practical nurse (LPN)-C and LPN-B entered at 3:45 p.m. to complete a right ankle dressing change. LPN-C and LPN-B performed hand hygiene and applied gloves. LPN-C removed R35's right sock and reported there was a sore on her great right toe, not previously observed. LPN-C stated the ankle dressing to be removed was dated 4/9/17 (two days prior). The soiled dressing was Kerlix and gauze that was saturated with foul smelling yellow/blood-tinged drainage. LPN-C reported no Allevyn was present on the ankle. R35 complained of pain when the dressing was removed. LPN-C described the wound as having "slough" (yellow fibrinous tissue that consists of fibrin, pus, and proteinaceous material) and said she could not visualize the wound bed. LPN-C stated the ulcer "was acquired because her ankles touch when she is in bed." LPN-C described the wound as "reddened with discoloration on the edges" and stated the wound measured 5 centimeters (cm) x 4 cm x 1.5 cm. LPN-B placed a barrier on the floor and placed supplies on the barrier. As she cleansed the wound with normal saline R35 screamed out, "That hurts!" LPN-B applied Santyl to the entire wound bed and edges, covered the wound with an Allevyn dressing, wrapped the entire area with Kerlix, and dated the dressing.

On 4/12/17, continuous observations were

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F 314	Continued From page 65 conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. Throughout the observation, R35 was not offered any assistance with repositioning or toileting. At 7:03 a.m. R35 was resting in bed with her eyes closed, slightly tilted to her right side. The room had a strong urine odor. At 9:53 a.m. NA-F stopped at R35's door, looked in and continued to walk past the room. R35 remained in the same position until at 10:02 a.m. at which time the surveyor attempted to locate an available staff person to intervene. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON stated she was unaware why care had not been provided for R35 but stated R35 sometimes resisted care. The DON stated she felt staffing challenges contribute to timely care for R35. The surveyor informed the DON of serious concerns regarding R35 and she responded, "Me too." The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an assessment of the resident's skin condition. The DON changed R35's incontinence brief and provided peri-care. The DON described R35's brief as saturated with dark colored pungent smelling urine. The DON acknowledged she was unaware of the last time R35 had been changed or repositioned. The DON then assessed the resident's skin condition and reported R35's left heel was lying directly on the bed. R35 moaned in pain and stated she "hurt everywhere" when assisted to turn to her right side. The DON stated the left ischial tuberosity had superficial skin loss over the previously identified Stage I from 4/11/17. R35 moaned, tightened her jaw and had furrowed brows when assisted to turn to her left side. The DON then observed the left heel, and stated there was a suspected deep tissue injury measuring 1 cm x 1 cm x 1 cm. R35 reported the area was painful to	F 314		

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touch. The DON put the gripper sock back onto the resident's left foot, which was directly on the mattress without a pressure relieving device in place. The DON confirmed she was aware of the status of R35's left heel last week, but did not know the severity of the wound and had not reassessed it. The DON confirmed a comprehensive assessment had not been completed or documented related to R35's excoriation on her buttocks, Stage I on left ischial tuberosity, and left heel deep tissue injury. The DON stated she would have expected these skin issues to have been assessed immediately upon discovery. In addition, the DON stated she expected staff to follow the resident's care plan and change and reposition R35 at least every two hours.

R35's record indicated the resident had multiple co-morbidities including: chronic kidney disease, signs/symptoms of peripheral vascular disease, dementia with behavioral disturbances, depression, and anxiety per her diagnosis list on the undated admission record, and consistent with a physician progress note provided by the facility following the recertification survey exit 4/14/17. Progress notes and medication/treatment administration records dated 1/6/17 through 4/13/17, indicated R35 had a history of intermittently refusing treatments and cares which included skin care treatment, assessments, physician appointments, and nutritional supplements.

A nutritional progress note dated 2/5/17, identified R35 had a low hemoglobin (8.7), low normal body mass index (19.3), and low normal body weight at 119 pounds. The nutritional progress note from 2/5/17, further noted R35's intake to be

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inconsistent, ranging from 26-100%. Nutritional goals were identified as: maintain stable weight, maintain hydration, and no skin breakdown. There was no further nutritional update.

R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 had moderate cognitive impairment and had diagnoses including: rheumatoid arthritis (known to contribute to pain), dementia and anxiety. The MDS further indicated R35 required extensive assistance with activities of daily living (ADLs), had no pressure ulcers but was at risk. The MDS indicated a formal assessment tool and a clinical assessment were completed to determine R35's pressure ulcer risk.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations due to: weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. The CAA dated 2/15/17, identified R35 to be at risk for skin breakdown. There was no comprehensive assessment of R35's risk factors contributing to the potential for breakdown. The CAA for cognition dated 2/7/17, indicated problems with short and long term memory, resident had daily behavior of calling out for assistance and can "disrupt others, but is not danger or disrupt cares". Although the care plan printed 4/12/17, and provided by the facility as current identified a refusal of cares, there were no interventions identified to assist staff on what to do in the event R35 refused cares/treatments. Additionally, there were no specific interventions to minimize the risk for skin breakdown based on identified risk factors.

R35's care plan dated 3/21/17, indicated R35 had

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an actual alteration of skin integrity due to being cognitively impaired, assistance with ADLs, neurodermatitis, and had scratches/wounds on both lower extremities, left buttock, shoulder, and chest. R35's care plan directed facility staff to assist with repositioning frequently in bed in order to help R35 avoid laying on the open areas. The care plan directed staff to ensure that proper pressure reducing devices were in the wheelchair, and that R35 was positioned correctly when transferring to wheelchair. Further, the care plan directed staff to "assist with repositioning in bed to avoid laying on open areas frequently". The care plan did not address R35's suspected deep tissue to left heel, unstageable ulcer to right heel, right inner ankle press ulcer, or right great toe wound. The care plan did not include interventions defining how often R35 needed to be turned/repositioned, nor did the care plan include other pressure reducing/relieving interventions.

During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down however, NA-F stated R35 did not decline offers to have her incontinence brief changed or offers to assist her reposition. NA-F verified R35 was unable to move herself. NA-F also stated that although R35 requested to use the toilet at times, she was unable to bear weight therefore, she required assistance to change her incontinence brief. NA-F stated if she observed a new skin alteration, she would inform the nurse at that time. NA-F denied being aware of open areas on R35's buttocks, but stated she had noticed red/yellow drainage from her right ankle on the bed sheet. NA-F stated R35 frequently complained of pain during the night.

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On 4/12/17, at 9:14 a.m. trained medication aide (TMA)-D said R35 yelled when staff did not respond to her requests for help. TMA-D also stated R35 received Tylenol for pain when she got up for the day, but not usually until 10:00 a.m. or 11:00 a.m.

On 4/12/17, at 1:44 p.m. nurse practitioner (NP)-A stated she was new to the facility and unfamiliar with R35. NP-A stated it was an expectation the staff would contact the NP regarding any new skin alterations, but verified she had not been informed of any problems with R35's skin since she'd begun seeing the resident on 4/3/17. NP-A said if skin alterations were observed, NP-A would institute orders to off load pressure and would implement pressure relieving interventions. If a new wound had developed, she would potentially order a Mepilex dressing.

A telephone interview was attempted with the medical director and a voicemail message was left on 4/12/17, at 2:19 p.m.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A. He reported he saw R35 for the first time on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. MD-A expected to be notified of significant decline in wounds. It was also expected daily dressing changes would be performed on R35's right ankle. MD-A reported R35 had a Stage IV ankle ulcer, and would have increased in size/severity without appropriate dressing changes. It was MD-A's impression the staff were elevating R35's heels, and at a minimum would have expected

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EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH** **RICHFIELD, MN 55423**

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the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks.

NA-A stated on 4/13/17, at 8:17 a.m. R35 "always says she is in pain" and was "cussing when getting dressed and putting her in the wheelchair." R35 complained of pain in her feet and legs. NA-A stated they are supposed to check on R35 every 15-20 minutes. Staff was supposed to ensure R35's feet were off the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.

On 4/13/17, at 8:28 a.m. LPN-D reported she was aware R35 had sores on her legs and hip. R35 slept from 10:00 a.m. to 1:00 p.m. but it was still expected the NAs would check on the resident because of her skin issues. LPN-D believed the right hip area was due to pressure, and the other wounds were from scratching and picking at herself. LPN-D was unfamiliar with other wounds, as they had not been passed on during shift to shift reporting.

On 4/13/17, at 10:56 a.m. NA-G stated she had repositioned and changed R35's wet incontinence brief at 7:00 a.m. NA-G stated the night shift had changed R35 at 5:00 a.m. NA-G reported R35 "screamed in pain" when assisted to reposition. R35 stayed in bed after incontinence care, and was reapproached at 10:00 a.m. and 10:35 a.m. to offer repositioning, but said R35 had refused. NA-G was unsure if R35 had wounds on her feet, or whether any changes had been made to her

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F 314	Continued From page 71 care plan in the last week. However, on 4/13/17, at 11:05 a.m. NA-H reported she had changed R35's incontinence brief at 7:30 a.m. and the resident had been incontinent of both bowel and bladder. NA-H was unsure when R35 had been changed prior to that time. NA-H was aware R35 had wounds on her thighs, toe, ankle, and heel. R35 had "a lot of pain" and would not let NA-H touch her right leg due to the pain. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's heels or feet. An interview was conducted with LPN-A via telephone on 4/13/17, at 11:12 a.m. LPN-A stated he worked on 4/10/17, but did not recall completing a dressing change that day. LPN-A stated when dressing changes were performed he usually dated and initialed the dressing, but at times was "busy and rushed" so may not have done so. LPN-A explained he had been the only nurse on the floor on 4/10/17, and "it was busy and difficult to get things done." LPN-A stated R35 was "in pain and every part of her body is sore." LPN-A was unaware of any other skin issues other than a pressure sore on the right ankle. On 4/13/17, at 12:30 p.m. the DON identified the following pressure related skin issues at the time of the survey: suspected deep tissue to left and right heel, right inner ankle, and right great toe wound. The DON stated R35's right ankle wound was first observed on 3/2/17 and though it had	F 314		

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F 314	Continued From page 72 been monitored weekly the record lacked evidence of monitoring. The DON was aware of R35's left heel ulcer on 4/12/17, but it was not reflected in the documentation. The DON stated that the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. Prior to the survey entrance the DON said she had not thought of putting a different mattress on R35's bed. The DON expected staff to reposition, check and change R35 at least every two hours. The DON expected nurses to monitor R35's skin every shift and assess once weekly on bath day, and to document findings. In addition, it was expected a comprehensive skin assessment would be completed when a new area was found. This included a head to toe assessment of skin, documentation of the location of wounds, wound measurements, with completion of a risk management form. The DON stated the current order for R35's right ankle was to apply Santyl, calcium alginate, cover with Allevyn and wrap with Kerlix. The expectation was for nurses to read the orders prior to completing the dressing change. The DON stated the right and left heel were to have skin prep applied, but verified this intervention was not identified on the Treatment Administration Record (TAR) or Medication Administration Record (MAR). The DON did not have any current in-service material showing staff had been provided education on wound training. The DON expected the nurse to immediately notify the NP when the skin alteration was observed, and the NP ultimately oversaw care for R35. The DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON	F 314		

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F 314	Continued From page 73 stated she felt it should have been. Review of R35's progress notes from 3/6/17, to 4/11/17, identified on 3/6/17, R35's right inner malleolus was painful to touch and tender and there was no notation regarding an update to physician. On 4/1/17, a skin check was completed with documentation of: "Other right heel-pressure stage unstagable, right ankle (inner) pressure- stage II" and identified no new skin areas. The following day on 4/2/17, documentation identified that the dressing charge to right ankle was completed and had a large amount of yellowish drainage from the wound site. Documentation lacked evidence that the provider had been notified. On 4/6/17, the progress note identified the right ankle dressing change was completed and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated. Review of R35's weekly wound documentation from 3/2/17, to 3/31/17. 3/2/17, right inner ankle was identified on this date by nurse manager with measurements of 2.0 x 2.5 cm and classified as an unstagable. Documentation identified that area was debrided on this date, depth is superficial, has 100% slough, a moderate amount of serous drainage, and pain associated with wound. Weekly wound documentation on 3/9/17, 3/16/17, 3/23/17, and 3/31/17, all indicated right inner ankle measurements of 2.0 x 2.0 x cm and classified as a stage IV. Documentation identified the depth was superficial with 100% slough and	F 314		

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moderate serous drainage, and pain associated with wound. Documentation had a radio button marked that indicated MD/Physician/NP/Medical Professional and family were notified. However, nursing weekly wound documentation and R35's record did not reflect the right medial heel.

Review of R35's weekly wound care specialist evaluation documentation from 3/2/17 to 4/7/17 revealed::

1) 3/2/17: unstageable (due to necrosis or dead tissue) of the right, medial ankle of at least 5 days duration with measurements of 2 cm x 2.5 cm x not measurable depth cm with light serous exudate and 100% thick adherent devitalized necrotic tissue. The wound was cleansed and using surgical technique was devitalized tissue and necrotic SQ (subcutaneous) fat was removed at a depth of 0.1 cm . There is no indication of pain associated with this condition.

3) 3/9/17: unstageable right medial ankle with measurements of 2 cm x 2 cm x not measurable depth with moderate serous exudate and 90% thick adherent devitalized necrotic tissue with 10% granulation tissue. Documentation identified no change in wound progress. The wound was cleansed and with surgical technique devitalized tissue and necrotic muscle and surround fascial fibers were removed. There is no indication of pain associated with condition.

4) 3/16/17: unstagable right, medial ankle pressure wound which had light serous exudate. Documentation identified that R35 appeared to have associated pain evidenced by agitation. Measurements were 3 cm x 3 cm x not measurable with 100% granulation tissue and

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wound progress deteriorated. R35 appeared to have associated pain evidenced by agitation.

5) 3/31/17: unstageable (due to necrosis) of the right, medial heel, of at least 1 day in duration. There is no exudate with measurements of 1.5 cm x 1.3 cm x not measurable. Documentation identified 100% thick adherent black necrotic tissue. Skin prep was ordered daily. Right medial ankle was documented of measurements of 4.0 cm x 3.5 cm x 0.2 cm with light sero-sanguinous exudate, 85% granulation tissue, 15% other tissue, and tendon visible. No indication of pain associated with condition.

6) 4/7/17: right medial heel with measurements of 2.0 cm x 2.0 cm x not measurable with 100% thick adherent black necrotic tissue and no change in wound progress. R35's right medial ankle was measured at 4.0 cm x 4.0 cm x .02 cm with maceration at periwound radius, moderate sero-sanguinous exudate, 15% other tissue, 85% granulation tissue and tendon observed. Documentation identified there was no change in wound progress, nor was there an indication of pain associated with condition.

The facility's undated Repositioning and Turning policy and procedure indicated: "Residents are turned/positioned in accordance with the plan of care to prevent skin breakdown. Residents who are unable to reposition themselves will be turned and repositioned every one to two hours in accordance with their needs, using a written care plan as determined by licensed staff. The Charge Nurse is responsible for incorporating the plan, approaches, and goal on the care plan."

A 4/21/14, facility specific Wound Care Program

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F 314	Continued From page 76 document indicated a Braden Scale was to be completed upon resident's admission and weekly for the first 4 weeks of admission to determine the score and the level of risk for skin breakdown. Then, the risk factor(s), potential cause(s) and interventions should be reviewed and addressed on the care plan. The document further indicated that when a resident is in bed or wheelchair they should be turned/reposition at least every two hours or as indicated on the resident's care plan. The care plan shall be evaluated and revised based on the resident's response to treatment, goals, and outcomes.	F 314		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 334		5/25/17

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(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and

(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-

(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;

(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;

(iii) The resident or the resident's representative has the opportunity to refuse immunization; and

(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:

(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and

(B) That the resident either received the

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F 334	Continued From page 78 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R89, R109) reviewed for immunizations were offered and provided the pneumococcal conjugate vaccine (PCV13) and 1 of 5 residents (R74) for the Influenza vaccine. Findings include: The Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R89's date of birth is 5/6/42. The facility supplied Immunization Report, run 4/11/17, had no documented evidence the PPSV23 and PCV13 had been offered. declined, or administered. R109's date of birth is 7/7/45. Review of the facility supplied Minnesota Immunization Information Connection flowsheet, run 4/11/17, identified R109 received the PPSV23 in 2011, however had no documented evidence the PCV13 had been offered, refused. or administered. R74's date of birth is 7/7/46. The facility provided Immunization Report, run 4/11/17, had no	F 334	All residents have the potential to be affected by this issue. -R89 consent has been updated and the PCV 13 vaccine has been given. -R09 consent has been updated and the PCV 13 has been given. -R74 consent has been updated and influenza vaccine was given prior to admission so consent denied. -Immunization policy and procedure has been reviewed and is current per CDC guidelines. -The facility completed an audit of vaccination records using multiple sources using EPIC, MIIC and EMR. Resident found not be current in their vaccination (influenza, PCV 13 and PPSV 23, were offered and given if consented. -New vaccination consent form was created and is in the admission packet and reviewed with new residents upon admission and at quarterly care conferences. -Education completed with facility staff on immunization, charting , tracking and administration. -Immunization audits will be completed within 10 days of admission and with quarterly care conferences. -Audits to be reviewed no less than quarterly at QAPI for determination of compliance and need to continue. -Infection control nurse or designee will be	

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F 334	Continued From page 79 documented evidence the Influenza vaccines had been offered, declined, or administered. On 4/11/17, at 1:52 p.m. director of nursing (DON) stated immunization status was screened prior to admission and would be in medical record if the resident had the immunization prior to admission. However, if there was no administration immunization records upon admission the residents had been offered, consented, and administered at the facility. The DON confirmed all documentation related to immunization status was provided, and there was no further information available. The "Seasonal Influenza Vaccine" policy dated 8/1/15, indicated the facility should screen residents and offer it to all unless medically contraindicated. The CDC Influenza Vaccine Information statement would be provided and a consent form shall be signed with a physician's order prior to administration. The resident will be monitored for 48 hours following administration. The "Pneumococcal Vaccination" policy dated 8/1/15, indicated residents would be assessed for receiving the pneumococcal vaccine. Consent and a physician's order would be obtained and the vaccine will be given following the CDC guidelines for the administration of the PPSV23 and PCV13.	F 334	responsible for audits. -Date of compliance 5/25/2017.	
F 353 SS=F	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 353		5/25/17

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provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
[As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)]

(a) Sufficient Staff.
(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (e) of this section, licensed nurses; and

(ii) Other nursing personnel, including but not limited to nurse aides.

(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(a)(4) Providing care includes but is not limited to

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F 353	Continued From page 81 assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was provided to meet the needs of residents regarding repositioning, pressure ulcer care, check and change programs, pain management, and assistance with ADLS. This deficient practice caused harm to R35. This had the potential to affect all 69 residents residing in the facility. Findings include: R86's family member (FM)-E when interviewed on 4/11/17, at 9:55 a.m. stated, "I come up here (3N) every other day after work, I think those residents here need activities." FM-E stated, "Since the new owners there is less staff, not enough nursing assistants (NAs)." On 4/11/17, at 10:15 a.m. FM-C stated R22 had moved up to 3N from the second floor. FM-C stated on the second floor staff did not always take R22 to the bathroom so the family would help assist him, staff seemed to put the same dirty clothes on him, and he had long toe nails. FM-C stated FM-B would lay out different clean clothes for R22 to wear the next day but staff would have the same dirty clothes on him. FM-C stated staff do not clean out his ears, and staff do not trim R22's nails. Staff do not always place his hearing aid in. FM-C stated they were still waiting to hear from the administrator about R22's missing hearing aid.	F 353	All residents could be affected by the alleged tag. -R35 passed away prior to receipt of SOD. -Residents with high acuity (skilled needs)or a change in acuity are reviewed daily at morning meeting Monday-Friday and for potential changes on Friday for the weekend with determination of appropriate staffing ratios and need for changes determined at that time. -A random sampling of residents throughout the facility,including those listed in SOD, have been interviewed to determine individual needs are met and are care planned appropriately. Interviews of all new residents will continue weekly for 4 weeks and of a random sample of at least 5 residents residing at the facility greater than 4 weeks will be done per week to determine ADL cares, pressure ulcer care and pain management needs are being met and have been care planned appropriately. -Staffing patterns have been reviewed and occupancy of individual units have been adjusted to reflect proper resident to staff ratios. -Audit of the staffing ratios via the staffing roster will be done daily Monday-Friday by the Administrator with adjustments made as needed to ensure adequate staffing ratios. -DON or designee will attend resident council meetings and/or meet with	

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EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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F 353	Continued From page 82 On 4/11/17, at 1:41 p.m. FM-F stated his family member fell about of bed last week and had an abrasion. FM-F stated apparently it was someone new working on the night shift. FM-F stated there used to be a full time social worker here that stayed on the unit most of the time and more games and activities happened, but now activities have decreased on the unit. R89's FM-E on 4/11/17, at 1:52 p.m. stated on a Tuesday about three weeks ago she had waited 35 minutes for staff to answer her family member's call light and there was no staff in sight. FM-E found NA-N and he helped her family member to the bathroom. His bed had been soaked and "reeked of urine". NA-N told FM-E he was the only NA who showed up for work that day. FM-E stated that working with one NA happens about four times a week here. FM-E stated she found the call light stuck approximately 10 inches under the mattress a couple of times when coming to visit R89. FM-E stated she found R89 on a wet bed but a dry pad a couple of times. R16 on 4/10/17, at 2:36 p.m. stated, "I have to wait 30 minutes, up to an hour for my night medication." R16's quarterly Minimum Data Set (MDS) dated 2/14/17, indicated R16's cognition was intact. R27 on 4/10/17, at 2:39 p.m. stated, "After three times the staff do not come in anymore. No one here cares." R27's quarterly MDS dated 3/15/17, indicated R27's cognition was intact. R47 stated on 4/10/17, at 4:18 p.m. stated, "They are so short on help, I wake up in the morning and have to wait an hour for help to get me dressed." R47 further stated "When you put your	F 353	resident council president to address resident concerns. -An audit tool was created to ensure ADL's, call lights and repositioning are done timely. These will be conducted 3X per week for 6 weeks and weekly thereafter for 3 months. Each audit will be done on 2 random residents per floor (6 residents per day). -Administrator/DON or designee will be responsible for audits. -Date of compliance 5/25/2017.	

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call light on you have to wait about 15 minutes, staff have told me they are short staffed." R47's quarterly MDS dated 12/28/17, indicated R47's cognition was intact.

R87 on 4/10/17, at 4:30 p.m. stated, "We are short of NAs, our nurses are leaving like flies." R87 stated they had a resident council meeting today and the administrator did not want to spend any money. The new SS is taking over today. R87's quarterly MDS dated 1/11/17, indicated R87's cognition was impaired.

R53 on 4/10/17, at 5:36 p.m. stated, "We are always understaffed, evening shift is the toughest and nights are short staffed also." R53 stated he has had to wait a long time for pain medications. R53's annual MDS dated 3/7/17, indicated R53's cognition was intact.

R67 on 4/10/17, at 6:15 p.m. stated, "I will put my call light on and have to wait for one half hour or more for some one to come in." R67 also stated they had been short of staff lately and there had only been one NA on the floor since the new ownership. R67's quarterly MDS dated 1/25/17, indicated R67's cognition was intact.

R89 on 4/11/17, at 9:18 a.m. stated, "I have to wait a long time when I put my call light on, and staff walk in here and help my roommate and when they are done with him I will say, Hey that was me that put on the call light. Four times they have just poked in their head and just left the room when I had my call light on, even when I was sitting on the edge of the bed watching traffic." R89's quarterly MDS dated 3/15/17, indicated R89's cognition was impaired.

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On 4/10/17, at 2:27 p.m. NA-K stated this last weekend there was one one NA on 3S for 17 residents and one NA can not help 17 residents get up in the morning. NA-K stated this last weekend there was only one NA on 2nd floor as well.
RN-A standing nearby stated the medical insurance was not good here and staff was working on other jobs. The facility was sold and they were cutting activities and housekeeping and staff did not feel it was fair to the residents. RN-A stated they are very short staffed here. There was only one person in the kitchen today out of four. RN-A stated staffing was getting worse and more often short staffed. RN-A stated one night there had been only one person, a nurse, on the whole floor. There were no NAs, just the nurse to pass the medications and provide cares for 17 residents.

On 4/11/17, at 1:25 p.m. housekeeper (HK)-C stated there were only two housekeepers today for the whole building and it's hard to keep everything up on the three resident floors and the basement room. HK-C stated it was difficult to keep the basement bathrooms' clean. HK-C stated they had talked to management about it but they were not doing anything but cutting down the janitor hours. HK-C stated there was no housekeeping staff to clean the dining rooms in the evenings and the resident room floors needed waxing. HK-C stated the facility was trying to cut down because of money.

On 4/12/17, at 8:08 a.m. RN-F stated the facility was short of staff. RN-F stated medical insurance went up a lot recently and RN-F was shopping for a new job. RN-F stated staff were mandated to stay after they had already worked an eight hour

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shift because they can not fill all the shifts. RN-F stated they were also short of NAs. RN-F stated sometimes only one NA works instead of the two NAs needed per shift.

On 4/12/17, at 8:44 a.m. NA-P stated two NAs were needed each shift for the 3N unit. NA-P stated sometimes they only worked with one NA. NA-P stated dietary did not pass out the residents meals, the NAs did and there were residents who needed meal assistance.

On 4/12/17, at 9:54 a.m. HK-C stated the facility was short of staff in every department. HK-C stated a lot of the staff were looking for another job since staff found out in February the cost of medical insurance increased so much.

On 4/12/17, at 2:00 p.m. maintenance director (MD) stated he recently became the director and had worked at the facility for three years in maintenance. MD stated the director recently left employment and the facility was not planning on replacing him. MD stated they had a list of things to do and had to prioritize what to complete as they often got pulled off tasks. MD stated he was in charge of four departments: laundry, housekeeping, janitorial and maintenance. MD stated last week he had to fill in for staff absences in each of the departments. MD stated they had been trying to update the facility this last year as well as keeping up with maintenance and repairs but they could not get to everything.

On 4/13/17, at 9:52 a.m. RN-F stated they picked up today instead of being mandated to double.

On 4/12/17, at 11:56 a.m. the administrator confirmed that this last Saturday night there was

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no NA working on the floor and only one nurse (RN-B) working on first floor with 13 residents. The administrator was asked how many NAs were working on the other floors that night. The staffing coordinator (SC) stated this last pay period had forty plus openings for nursing assistants and forty plus openings for nurses that they were unable to fill.

Five minutes later at 12:01 p.m. administrator came back and stated it was Monday night and not Saturday night when there was no NA on first floor for the night shift. The administrator further stated on Monday night there was one nurse and only one NA on second floor and one nurse and one NA on third floor Monday overnight. The administrator stated there should have been two NAs overnight on second floor, two NAs on third floor, and one NA on first floor. The administrator stated the facility could not use float pool or agency as of 3/31/17, when the new ownership was in place.

On 4/13/17, at 10:22 a.m. the assistant director of nursing (ADON) stated she worked at the facility for 2 1/2 years with 1 and a half years as the nurse manager for the transitional care unit (TCU). The ADON stated it had been 2-3 weeks now since she had been asked to also be the nurse manager for the 3N unit. It was when the new owners revamped and she was now called the ADON instead of nurse manger. The ADON stated the facility thinks it's manageable for her to be nurse manager of 3N and the TCU. The ADON stated the TCU can be very busy. The ADON stated the DON was the nurse manager for the other three units of long term care. The ADON stated she did not know the residents of 3N very well yet. The ADON stated since having

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F 353	Continued From page 87 new ownership the facility had been working with only one NA and not the two NAs they usually had. The ADON stated the facility can no longer use the float pool/agency. They had been utilizing agency for three full time positions before the change of ownership. The ADON stated she was interviewing staff about the residents on the 3N unit because she did not know the residents yet. The ADON stated 3N presently has 14 residents on 3N and TCU number of residents vary, currently having 13 residents. The ADON stated the TCU is very time consuming. On 4/13/17, at 2:22 p.m. the director of nursing (DON) stated she had been DON for two weeks. The DON stated she had previously been the nurse manager for the two units on second floor. The DON stated the ADON was now the nurse manager for TCU. The DON stated RN-G had been the nurse manager of two units on the third floor but had left employment with the facility in 2/17. The previous DON had left employment 3/27/17. The DON stated RN-E had become the new ADON when she became the new DON. The DON stated the facility used to have someone in charge of education. She stated the previous educator had left in 3/17 and she would be responsible for completing training with the staff. The DON stated the ADON was supposed to be doing all nurse management duties for the whole facility, but did not agree with those responsibilities. She stated the ADON only wanted to do three units, the TCU units she had been previously doing and the one 3N unit. The DON added the ADON was leaving employment with the facility next week. The DON stated residents in the long term care units on second floor come to her with their concerns and the nurses on the floor help complete the resident	F 353		

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assessments. The DON stated she is going to have two ADON's with nurse manager responsibilities. The DON stated the consultant is going to help hire an ADON.

R60
During an family interview on 4/10/17, at 2:02 p.m. R60's family member (FM)-A stated she noticed some staff issues in the facility. FM-A explained R60 required 2 nursing assistants (NA) and the use of a hoyer lift to transfer. R60 relied on transportation to and from appointments using metro mobility. However metro mobility will only wait 5-10 minutes then they will leave with or without you. FM-A stated that on more then one day the floor is only staffed with one NA so she had to be the second person to help transfer R60 with the hoyer lift or they would miss there ride with metro mobility. FM-A also stated that new staff have not been trained on how to properly use a hoyer lift because they were put on the floor so fast due to the shortage. "I feel sorry for the residents who can't speak for themselves."

During a meal observation on 4/10/17, at 5:55 p.m. residents were served a plain hamburger with no condiments. The only staff serving the residents was the nurse, however three residents requested ketchup, but only one resident was able to get up on his own and get a packet out of the refrigerator. The other two residents finished their hamburger without getting ketchup. The nurse was observed helping another resident onto the elevator and left the floor in the elevator. Four residents sat at the table with no meal for them to eat. At 6:06 p.m. the two NAs entered the dining room and brought the four resident's their meals.

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F 353	Continued From page 89 On 4/11/17, at 9:20 a.m. NA-N stated when the State is here management scheduled two NAs but usually there was only one NA. "If my phone rings I don't answerer it because I know the [facility] wants me to pick up a shift and I will have to work the floor all alone." On 4/12/17, at 7:34 a.m. NA-O stated she was a regular on the floor and sometimes there was only one NA when there should be two, "it's hard to get the work done on time." NA-O further stated the licensed nursing staff does not help to answer call lights. NA-O explained just last Friday she was the only NA on the floor and NA-L was being trained in when management pulled the person training her to another floor so she did not get the training she needed. On 4/12/17, at 10:12 a.m. the DON explained that staffing challenges contributed to the lack of timely cares on R35. The DON stated the facility attempted a staff to resident ratio of 10:1, however, felt the second floor suffered the most due to having more residents with higher acuity. Although, the facility staffs the more experienced NAs on the second floor they are slower. The DON was made aware of serious concern due to lack of care for R35 and she responded "me too." The DON stated the director of nursing role and charge nurse duties are difficult to do. Further, she stated she had talked to some of the floor nurses to assist with the charge nurse duties and are in the process of hiring. The DON stated she cannot do both roles but at the time of survey she was "unable to talk to their corporation due to Pass-Over Holiday." The DON mentioned that she had not been able to put R35's wound measurements in the record as she had not gotten to them yet.	F 353		

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F 353	Continued From page 90 On 4/12/17, at 9:14 a.m. HUC-A stated her role is to schedule rides, appointments, referrals, and coordinate care between doctors for the residents. She further explained that she was usually pulled from that role one to three times per week to be a medication aid throughout the building depending on staffing "if they are short". HUC-A stated it depends on the day if she has enough time to get both jobs completed. HUC-A explained she does get pulled away from passing medications to complete medical record responsibilities. HUC-A stated the facility is usually short due to call ins which are handled by staffing coordinator or the night supervisor and are usually 25% successful at filling a shift if that occurs. HUC-A stated she had heard residents and staff complaining of being short staffed. Further, explained the NAs complained about not having enough time to get cares done and to meet the needs of the residents. HUC-A felt the DON and administrator know about the short staffing and had in fact discussed with the DON last week. HUC-A stated the facility is working on hiring people and sees new employees start in orientation. HUC-A explained new employees stay for approximately a month and then leave because the job is too hard. HUC-A is unsure if facility had done anything additional to continued hiring like adds, job fairs, etc. On 4/12/17, at 1:44 p.m. NP-A stated a situation occurred last week which prompted her to have a conversation with the DON and her concern for staffing. NP-A informed the DON she would partner with her for education for the nursing department, NAs, and proper notification. NP-A stated the facility had large staff turn over with the recent change of ownership and the employees cannot afford the insurance so they left.	F 353		

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On 4/12/17, at 2:43 p.m. NA-A stated that she usually worked on the third floor but today was pulled down to the second floor due to short staff. There is supposed to be three NAs working on the second floor but one left at 10:00 a.m. due to an emergency. This staff was not replaced and there were two NAs for all of the residents on the second floor. She stated that today she will have to stay overtime to chart.

Registered nurse (RN)-D, on 4/12/17, at 10:48 a.m. she stated there was not adequate staffing so had a hard time finishing work. She stated the facility had trouble with staff retention. On 4/12/17, RN-D covered two medication carts and 26 residents during her shift. She stated that she was overwhelmed that day. RN-D stated there were two residents on the second floor that were supposed to get out of bed daily but this did not happen every day when there was not enough staff.

R35's Minimum Data Set (MDS) dated 2/7/17, identified R35 was moderately cognitively impaired.

On 4/11/17, at 8:17 a.m. writer heard R35 calling out "help me" from behind a closed door without staff in the area. Writer advised Health Unit Coordinator (HUC)-A R35 was calling out "help me" continuously from her room with door closed. HUC-A opened door revealing R35 in her bed laying partially on her right side with face contorted and still calling out "help me". When R35 saw HUC-A she stated "where were you? I have been calling for a half hour and I am scared. I thought you forgot I was here."

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On 4/11/17, at 8:20 a.m. during an interview with HUC-A she stated when she walked in R35's room she was facing away from her call light button and could not reach it. HUC-A stated R35 said she had been calling for a long while and when no one came she was scared. The call light was hanging from a grab bar attached to R35's bed and she probably could not reach it.

On 4/11/17, at 8:23 a.m. during an interview with R35 she stated she had been yelling help for 1/2 hour before someone came. R35 stated she was scared because she thought the staff forgot where she was and she wanted to get up but could not reach the call light so she started calling out. R35 further stated the staff never responded when she calls for them or when she presses the call light.

On 4/11/17, at 8:29 a.m. Nursing Assistant (NA)-A stated sometimes there is not enough staff working so it makes double work the rest of the staff. We are short today. It takes a long time to get all the residents up in the morning and dressed and there are only two of us on second floor today. I think we need more staff because we can't take care of the residents like we are supposed to. Call lights can take a long time to get to and residents stated they do not get their breakfast on time or they had to wait a long time to get on the bedpan.

On 4/12/17, at 10:10 a.m. the executive director stated the facility was sold as of 3/6/17, and they created staffing ladders per diem per patient day. We did not factor acuity into it. There is a per diem for nurses and NA's. We quit using agency staff on 3/31/17, and they had previously accounted for about 20% of our staffing for

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F 353	Continued From page 93 nurses and NA's. We did not know we were not going to be able to use pool staff until one week before the sale of the facility. On 4/12/17, at 10:30 a.m. the staffing coordinator stated they were not able to fill the staffing needs for the facility at this time. The facility had 40 open NA shifts and 49 open nursing shifts the last two weeks. If an employee called in sick the facility instituted mandatory overtime if we determined the number of staff working could not provide safe care to the residents. We have had to mandate overtime and have had a lot of staff working double shifts. We have not been able to staff the shifts adequately the last 2 weeks. Sometimes there was only one NA on the 3rd floor on the night shift. We had a NA call in sick on 2nd floor days and evenings so we were short over the weekend. On 4/8/17, we could not fill 3 NA day shift positions in the facility. On 4/7/17, we were short two NA 's on night shift on TCU and 3N. There was a NA who did not call in sick or show up on TCU for their evening shift but I know another nurse stayed even though it is not indicated on the printed schedule. Some days our staffing is good some days not. We have had complaints everyday from NA's and nurses regarding the staffing shortage and having to work more shifts and longer hours. A few residents have complained about staffing also. On 4/12/17, at 8:28 a.m. RN-B stated staffing was frustrating. There are a lot of call ins they are unable to replace. The staff left working are frustrated when someone calls in sick because then they have to work harder and longer. Some irresponsible staff are calling in a lot which makes a lot of work for the rest of the staff. If it is unsafe for the residents the facility mandates overtime for nursing staff. This morning was mandated to stay over from night shift because it would have	F 353		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

(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 353	Continued From page 94	F 353		

been difficult for just the day nurse to give all the medications on the second floor. When we are short staffed the residents know and they don't ask for things they may usually ask for. Call lights are not answered as quickly and residents state they have had to wait.

On 4/12/17, at 10:06 a.m. NA-B stated this morning there was only one scheduled nurse which is not enough for this many residents. In order to do things well for the residents they needed three NA's working on both the day and evening shifts. NA-B further stated they have had to work short for the last few weeks.

On 4/12/17, at 3:08 p.m. the executive director stated the facility was currently accepting admissions.

On 4/13/17, at 8:23 a.m. the DON stated staffing was a concern. When the facility was sold we were told we were not allowed to use float pool staffing after 3/31/17. We started hiring at that time and kept three of the float pool staff members. Our staffing over the last month has been a struggle and we have had to work short, especially with the NA staff. The struggle with filling staffing holes affected the residents by having them wait longer for call lights to be answered but I think the cares got done. I am the now the director of nursing (DON) and have not worked as a charge nurse but do supervise the second floor. I assign specific tasks to other staff members. On 3/27/17, I transferred to my role as DON. I know the daily schedule has me listed as the charge nurse but it is a name only thing. My job is only DON and I have never functioned as a charge nurse since being named DON.

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F 353	Continued From page 95 On 4/13/17, at 12:17: p.m. the executive director stated the DON started on 3/25/17, and she has not worked as a nurse manager after that day. The Daily Staffing Schedules were wrong and the DON is in charge of the building but the ADON is the actual charge nurse of all 3 floors on the day shift. We do not have call light logs but we do audits on dining and call lights every weekend which we put into a summary. While auditing we also handle any staff or resident concerns or grievances that arise. We round throughout the facility, help serve a meal and monitor call lights. We stopped doing the audits on 3/6/17, but will be starting them back up next weekend. My expectation is a seven minute response time for call lights, and if this is not accomplished, we will do staff education and corrective action. On 4/3/17, at 12:22 p.m. the staffing coordinator stated the policy used for staffing was the previous owners policy.	F 353		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 371		5/25/17

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(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure sanitary food was served to 3 of 13 residents (R20, R55, R17) served a meal in the 3N dining room. This had the potential to affect 9 additional residents in the 3N dining room. In addition, the facility failed to ensure refrigerators were sanitary in kitchenettes on 3 of 3 units observed.

Findings include:

3N Meal Service
On 4/10/17, at 5:31 p.m. 13 residents were observed sitting at tables in the 3N dining room. At 5:40 p.m. another resident walked in and sat down.

At 5:41 p.m. the cook was observed standing behind the steam table touching the residents' meal tickets with gloves on. The cook then picked up a bun, broke it in half and placed it on a plate, meat was picked up with her gloved hand, placed on the plate, and taken out to the dining room. The cook pulled foil off the pans of food on the steam table, walked over to the garbage can and with both gloved hands pushed down the cover of the dirty garbage can cover.

Has potential to affect all residents of the facility.
-R20 experienced no adverse event from this issue
-R17 experienced no adverse event from this issue
-R55 experienced no adverse event from this issue
- As soon as notified of this event the dietary manager directed the staff member to change gloves using proper technique. Residents plates that had been set up after gloves became soiled were replaced prior to the resident eating.
-Dietary gloving policy has been reviewed and is current.
-Staff have been educated on appropriate gloving and re-gloving when serving food.
-As soon as the notification occurred all un-covered, undated and outdated food was removed from the refrigerator and spilled food was cleaned up and any food product that the spilled food was in contact with was thrown away.
- Staff have been educated on proper food storage on unit.
-Refrigerator cleaning schedule has been updated and staff trained.

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F 371	Continued From page 97 At 5:45 p.m. while holding a plate in the same gloved left hand, the cook scooped ground rice and mashed potatoes for R20. The cook placed her same gloved left hand on the yellow wet sign behind her and with the gloved right hand touched her clothing and pulled up her slacks. The cook picked up a plate with the gloved left hand and picked up a bun with the gloved right hand, used tongs to place a hamburger on the plate. With the gloved left hand turned the hamburger around on the plate for R55 and touched the bun for R17 with the same gloved hands. The cook was going to have nursing assistants take the plates out to the residents when the surveyor intervened. The Dietary Director (DD) was informed of observation with the gloves touching the dirty garbage can cover touching residents' food with the same dirty gloved hands. DD instructed the cook to take off her gloves and put new gloves on and instructed cook to throw the three plates of food away. DD also stated the cook should not be touching the individual residents' meal tickets as staff and residents touched them. Cook stated she had been a cook for almost one month and a half, was trained to wear gloves and would take the gloves off after going downstairs to the kitchen. Policy provided by the facility Bare Hand Contact with Food and Use of Plastic Gloves dated 2010, indicated "Plastic gloves will be worn when handling food directly with hands to ensure that bacteria are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited. Gloved hands are considered a food contact surface that can get contaminated or soiled. Anytime a contaminated surface is touched, the gloves must be changed."	F 371	-Refrigerators have been cleaned. -Refrigerators will be monitored daily and items that do not meet with facility policy will be discarded. -Food policy has been reviewed and is current. - Audits will be completed on refrigerators, dining audits and gloving audits 2X weekly X3 then weekly. Audits to be reviewed at QAPI for determination of compliance and need to continue. -Dietary manager or designee will be responsible for audits. -Date of compliance 5/25/2017	

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F 371	Continued From page 98 On 4/10/17, at 12:34 p.m. during a tour of dietary services with the DD, it was noted each floor had a refrigerator. The third floor refrigerator contained a bowl of oatmeal, not dated or sealed. There is a darker colored liquid spilled in the drawers and there were butter packs and milk creamer containers sitting in this liquid in the drawers. In the second floor refrigerator, there were two sealed containers of spaghetti on the shelf not dated or labeled. In the first floor refrigerator, the freezer had what looked like cherry pie on a plate not covered, sealed or dated. All three refrigerators had spilled food and were not clean. The DD stated that maintenance was responsible for the cleaning of these units. On 4/11/17, at 8:24 a.m. the maintenance director (MD) stated he was not aware that his department was responsible for this and he would "check into it." He stated he had been the maintenance supervisor for approximately one month, so he didn't know who was responsible, but would find out. On 4/11/17, at 9:15 a.m. the DD stated the refrigerators were the housekeeping responsibility and they had been cleaned. The MD stated he did obtain a cleaning schedule and it was provided to the surveyor.	F 371		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 431		5/25/17

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law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
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.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

(2) The facility must provide separately locked, permanently affixed compartments for storage of

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F 431	Continued From page 100 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 failed to ensure medication carts were locked to minimize the risk of drug diversion for 1 of 7 carts. Finding include: On 4/12/17, at 7:41 a.m. 3 North's medication cart was observed in the hallway unlocked and no staff was observed on the unit. R27 walked by the unlocked medication cart and continued toward the dining room area. A maintenance staff and the unit nursing assistants walked by the cart and proceeded with their normal routine. At 7:51 a.m. registered nurse (RN)-C was observed coming out of R60's room and walked over to the unlocked medication cart. RN-C verified she was the nurse working on the medication cart and immediately stated she forgot to lock the cart when she went into R60's room. RN-C explained the facility policy and procedure is to lock the cart every time you leave it. RN-C verified while the cart was unlocked residents and staff could take medications. On 4/13/17, at 8:47 a.m. the director of nursing stated her expectation regarding medication carts was they were to be locked at all times when staff was not present.	F 431	This issue has the potential to affect all residents in the facility. -Unlocked medication cart was assessed and no medications were missing. -Policy regarding medication cart has been reviewed and is current. -RN C -Nursing staff was educated on locking medication carts when unattended. -2-3 Audits on locking medication carts will be completed 2 x weekly, x 3 weeks then weekly thereafter. Results brought to QAPI for determination of compliance and need to continue. -DON or designee will be responsible for compliance. -Date of compliance 5/25/2017	

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F 431	Continued From page 101 On 4/13/17, at approximately 9:30 a.m. R43 was observed wandering around 3 North. When R43 reached the medication cart she attempted to pull on the drawers which were locked. She then she reached into the trash on the side of the cart, pulled out a plastic cup, looked at it placed it back in the trash. The facility's policy and procedure titled "Medication Storage" dated 8/1/15, indicated compartments containing medication should be locked when not it use.	F 431		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the	F 441		5/25/17

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Continued From page 102
facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their

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F 441	Continued From page 103 program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to prevent and control the spread of infection related to the cleansing of the blood glucose monitoring machines. This had the potential to affect 5 of 5 residents on the second floor who shared the same glucometer. Findings include: On 4/10/17, at 6:35 p.m., licensed practical nurse (LPN)-A performed a glucometer check on R70. After leaving the room, LPN-A cleansed the glucometer with an alcohol wipe. At 7:21 p.m. LPN-A confirmed he cleaned the glucometer with an alcohol wipe. LPN-A stated he should have used saniwipes to clean the glucometer but the facility was out of saniwipes. LPN-A identified the glucometer is used on multiple residents. On 4/12/1, at 7 8:05 a.m. (RN)-D wiped off glucometer after using on resident with Saniwipe, then got a new Saniwipe and left glucometer wrapped in wipe for at least two minutes. On 4/13/17, at 9:40 a.m. registered nurse RN-C stated 5 residents currently used the glucometer that was cleansed with alcohol wipes. RN-C stated proper cleansing of glucometers is to wipe off glucometer with saniwipe and then wrap glucometer in saniwipe for two minutes. The director of nursing (DON) stated on 4/12/17, at 3:18 p.m. that staff was expected to clean the glucometer with one saniwipe and then wrap the glucometer in another saniwipe for 2 minutes. The DON stated there were saniwipes available	F 441	This has the potential to affect all residents I=with diabetes I the facility. - Facility now using individual glucometers for diabetic residents. - the procedure for cleaning and disinfecting glucometer machines is available on each unit -facility will ensure that an adequate supply of germicidal cleaning cloths is available on each unit and restocked as needed. -individual education completed with LPN A -Education on glucometer use and cleaning completed with staff. -2-3 Audits on glucometer use and cleaning to be completed 2x weekly x3 then monthly and reviewed at QAPI for compliance and need to continue -Don or designee to be responsible for compliance. -Date of compliance 5/25/2017	

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F 441	Continued From page 104 in the building on 4/10/17. The facility's undated policy "Maintaining the Blood Glucose Meters" identified to clean and disinfect the meter, use pre-moistened wipe/towel of 1 ml or 5-6% sodium hypochlorite solution (household bleach) and 9 ml water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hypochlorite.	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a functional and comfortable environment. This affected one resident R5 with comfortable temperatures and had the potential to affect all 69 residents residing in the facility. Findings include: On 4/12/17, at 2:00 p.m. the maintenance director (MD) stated he became the director a month ago and there was another maintenance staff who worked full time. MD stated staff notified	F 465	-This tag has the potential to affect any resident.\ -the small circular gouge on bathroom drawer to room 202 has been repaired -room 311 closet door has been replaced and the bottom drawer of this closet has been replaced. -the cracked ceramic tile in bathroom of 311 and ceiling tile in 311 have been replaced - room 319 room door and bathroom door	5/25/17

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F 465	Continued From page 105 him of work requests either on his cell phone or with TELS orders on the computer. During the environmental tour on 4/12/17, at 2:00 p.m. verified a small circular gouge on the room door in room 202 he had not been aware of. MD took temperature of room 221 and laser gun read 68 degrees by the window and 70.5 degrees by the bed. MD stated, "I think I know why it is cold in this room" and went over to the window and closed window tight. MD stated the window had not been completely closed and that he knew why. MD stated staff had come to him last week on one of the 70 degrees days and wanted to be able to open that window. MD stated it took a tool to open the window. MD stated now with the window completely closed up tight the room should now hold its heat. MD stated he did not think staff were aware of how to close the window tight and how that affected the temperature in the room. The following morning on 4/13/17, at 10:26 a.m. in room 221, MD verified the temperature with a laser gun was 66 degrees under the window and 72 degrees by the bed. MD stated the boilers were turned on for the night and off for the day. MD stated closing the window had eliminated the draft coming into the room. MD stated it still felt chilly in the room and took temperature of the window on the opposite of the room and it read 59 degrees, 62 degrees and 64 degrees on each individual pane. A draft was felt on the right side of the window. MD verified what looked like old sticky tape on the window. MD stated looks like there once was a draft block tape felt and could redo it to help keep the draft out of the room. MD stated he did not know what temperature range	F 465	were repaired and wall between residents beds were repaired and repainted -new counters and sink in 3n kitchenette were replaced -missing closet door in 307 was replaced and closet door was replaced - soap dispenser in 307 has been repaired -television in 307 has been replaced -wallpaper on 3S near elevator has been repaired -windows in 221 were closed and temp of room returned to normal range -sheet rock on walls between 108 and 109 have been repaired, gouged holes in sheetrock across from room 107 and scratched walls by room 100 have been repaired -chip marks on 3N unit have been repaired -plaster spots on 1st floor by east door have been repaired -facility will have a prevenative maintenance plan in place by 5/25/17 -maintenance dept will conduct 2-3 audits weekly of resident care areas and repaired items and noted above -staff educated on how to report repair needs to maintenance.date of Compliance 25, 2017 Audit results to be reviewed no less than quarterly and taken to QAPI for determination of compliance and need to continue -Maintenance Supervisor or designee responsible for compliance Date of compliance 5/25/2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING ______ B. WING ______	04/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

(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 465	Continued From page 106	F 465		

the facility should be but stated it should be what the residents wanted. MD stated he would fix the window in the room and that should help warm up the room. R5 was wheeling self down the hall to her room 221 and stated to MD that her room was still cold this morning. MD told R5 about her roommate's window being drafty. R5 stated she hated feeling cold and had wondered if that window had been drafty but had not mentioned that to staff or to MD the last time he had helped with her window in the room. MD stated he would put a covering on her roommate's window to cut down the draft. (R5 had complained of being cold in her room on 4/12/17, at 9:50 a.m. to another surveyor for the last few months and that staff was aware. R5 also stated that NAs would come in her room and try to heat up the room by turning up the thermostat but R5 would tell the NAs no, as it just blew cold air.)

On 4/12/17, at 2:00 p.m. in room 311, MD verified the bottom drawer of the closet was missing leaving a metal bracket exposed. MD also verified a large gouge on the bottom of the closet door he had not been aware of. MD verified cracked baseboard tile along the bathroom floor wall in bathroom and large cracked splitting ceiling tile almost in half holding the vent which MD stated he had not been aware of. MD stated it looked like a mop handle had hit it.

In room 319 MD verified the room door and the bathroom door were scratched up through the middle and a large portion of the wall between the residents had missing paint. MD stated he had not been aware of the room needing paint but had been aware of the scratched doors. MD stated he thought the door handle was scratching the other door.

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	245275	A. BUILDING ______ B. WING ______	04/14/2017

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EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423**

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F 465	Continued From page 107 On the 3N unit, MD verified cabinets were sitting in cardboard boxes by a plastered wall. MD stated the plan was to put new cabinets, counter and sink in. MD stated the old cabinets and sink had been taken out four weeks ago and that he was hoping to get the new counter put in next week. MD stated the old cabinets and sink had been removed to update the dining room and make it look nicer. MD stated it had unfinished for about a month and hoped he could find time to at least get back to it next week. In room 307, MD verified a missing closet door and the soap dispenser did not work. Small trickles of soap would come out of dispenser with continuous pressure put to it. MD stated he had known about the soap dispenser not working and thought it may needed new batteries which he had not replaced yet. MD stated the closet door had been off for over a month and they had not been able to get to it. MD stated the frame needed more wood before the new door could be put on as it would leave a gap. During the tour, Family Member (FM)-B came out of room 307 and told MD the television in the room did not work. FM-B told MD the television had stopped working over the weekend and she told staff. MD stated he had not been informed by staff and that he would get a new television put in this afternoon. MD verified the television did not work and needed replacing. MD stated it was a facility television therefore the facility needed to replace it. On the 3S unit, by the elevator MD verified missing wallpaper approximately half a foot and also wallpaper few inches ripped in the hall to the right of room 319. MD stated he had not heard of any plans for the 3S unit. MD stated they were trying to triage the work and look residents' rooms over when residents	F 465		

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	245275	A. BUILDING ______ B. WING ______	04/14/2017

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F 465	Continued From page 108 discharged. MD stated they had been busy updating the facility and trying to do things as they were noticed. MD stated they were called off to do other things and had to prioritize the work. MD stated he had a list of things to get done. MD stated he had no work requests for any of the things looked at on the tour. On 4/13/17, at 10:26 a.m. on first floor MD verified plaster on the walls between rooms 109 and 108 plastered holes and a gouged hole in the plaster across from room 107, and scratched walls in the hall by room 100. MD stated hall walls needed continual touch-up. In room 221, MD verified four holes with blue putty sticking out above the sanitizer dispenser on the wall and stated it had always been that way and it did not look nice. In room 223, MD verified holes in the closet door, stating he could use stain putty to repair. MD added last week he had to fill in for every department under him (laundry, housekeeping, janitorial, maintenance) as staff had been absent. In 3N unit, MD verified white chipped marks on the wall across from the elevator stating they needed touch-up and that walls were a constant touch up due to residents' wheelchairs. On 4/13/17, at 12:11 p.m. MD verified plastered spots in halls on first floor at the entrance door and at back stairway door. MD stated wall touch ups was needed ongoing from wheelchairs, and that he would need to touch up. MD stated the facility no longer had a Preventative Maintenance plan, had had one at one time but had been busy with remodeling. MD stated with new ownership would now be two maintenance instead of the three fulltime maintenance the facility had. MD stated the previous director had recently left employment and would now just keep two maintenance, was a new ownership decision. MD	F 465		

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F 465	Continued From page 109 stated he would need to put a plan in place for Preventative Maintenance. MD stated he did not have any work order requests for the environmental issues verified. MD stated he was not aware of any environmental/maintenance policies for the facility.	F 465		
F 468 SS=E	483.90(i)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS (i)(3) Equip corridors with firmly secured handrails on each side; and This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to secure handrails on 2nd floor potentially affecting 26 residents and visitors. Findings include: On 4/12/17, at 2:00 p.m. the maintenance director (MD) stated he had recently become the director and there was another maintenance staff who worked full time. MD stated staff notified him of work requests either on his cell phone or with a TELS order on the computer. During environmental tour on 4/12/17, at 2:00 p.m. MD verified on 2nd floor throughout 2N and 2S halls, the hand railings were loose. MD tightened each hand rail with his screw driver. Two of the hand rails, one on 2N and one on 2S, were unable to be tightened and remained loose from the wall. One rail was to the right of room 213 and the other one to the left of the day room. MD stated he would need to replace the handrails as the screws had been stripped. MD stated he would need to prioritize this due to safety concerns as residents used the handrails. MD	F 468	All resident in facility have potential to be affected -handrails were inspected and repaired by Maintenance staff -staff educated on placing maintenance work order using TELS system -Audits on 2-3 hand rails to be conducted weekly x3 then monthly and results brought to QAPI for determination of compliance and need to continue -Maintenance supervisor or designee responsible for audits Date of compliance 5/25/17	5/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245275	A. BUILDING ______ B. WING ______	04/14/2017

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EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423**

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F 468	Continued From page 110	F 468		

stated these handrails were the same ones as long as he had been working at the facility which was three years. MD stated handrails wear out with normal use from the pressure of residents and possibly visitors using them. MD stated he may need to take the handrail by the dayroom off of the wall as it was too loose and may come off during use. MD stated he was not aware the handrails were loose. MD stated he performed no audits of checking handrails. He would only know if the handrails were loose if staff notified him and they had not; he had no work requests for handrails.

MD stated the department had been keeping busy updating the facility and trying to do things as they noticed it. MD stated they got interrupted to do other things and had to prioritize. MD stated he had a list of things to get done. He further stated he was promoted to director about a month ago. MD stated the previous director left and the plan was not to replace him.

On 4/13/17, at 10:26 a.m. MD stated he had been able to snug up the handrail to the left of the day room on second floor. MD attempted to tighten the other handrail on second floor to the right of room 213 but stated it would not last because of the sheetrock/cement. MD stated he would set up a monthly check for all handrails acknowledging it was a safety precaution.

On 4/13/17, at 12:11 p.m. MD stated the facility no longer had a Preventative Maintenance plan. MD stated going forward he would need to put a plan in place. He was not aware of any environmental/maintenance policies for the facility.

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

F5275026

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 04/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 11, 2017. At the time of this survey, Edina Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 4, 2017

Mr. John Doughty, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, MN 55423

Re: State Nursing Home Licensing Orders - Project Number S5275027

Dear Mr. Doughty:

The above facility was surveyed on April 10, 2017 through April 14, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules . At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the licensing orders cited herein are not corrected, a civil fine for each licensing order not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Maria King at (507) 344-2716 or email: mark.meath@state.mn.us**.

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

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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00740	A. BUILDING: ____ B. WING ____	04/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/10-14/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's	2 265		5/25/17

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2 265	Continued From page 2 physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promptly notify the physician when a pressure ulcer developed and worsened for 1 of 1 residents (R35) reviewed. Findings include: R35's progress notes from 3/6/17, to 4/11/17, identified on 3/6/17, R35's right inner malleolus was painful to touch and tender and there was no notation regarding an update to physician. On 4/1/17, a skin check was completed with documentation of: "Other right heel-pressure stage unstagable, right ankle (inner) pressure-stage II" and identified no new skin areas. The following day on 4/2/17, documentation identified that the dressing change to right ankle was completed and had a large amount of yellowish drainage from the wound site. Documentation lacked evidence that the provider had been notified. On 4/6/17, the progress note identified the right ankle dressing change was completed	2 265	Corrected	

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2 265	Continued From page 3	2 265		

and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated.

Weekly wound care specialist evaluation documentation reviewed from 3/2/17, to 4/7/17 indicated the provider was aware of R35's right medial ankle pressure ulcer on 3/2/17 and right medial heel on 3/31/17.

On 4/11/17, at 3:20 p.m. the DON assessed R35's skin condition. The DON described R35's skin as: right upper buttock was open and excoriated from moisture; left ischial tuberosity is boggy and non-blanchable; the left bottom buttock is reddened but blanches; right ischial tuberosity is blanchable; right lower extremity has sores and scabs which have Tegaderm dressings on them; right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON verified was soiled with blood and wound drainage.

After the NAs and the DON left the room, licensed practical nurse (LPN)-C and LPN-B entered at 3:45 p.m. to complete a right ankle dressing change. LPN-C described the wound as "reddened with discoloration on the edges" and measured 5 (centimeters) cm x 4 cm x 1.5 cm. R35 screamed out, "That hurts!" during the dressing change.

On 4/12/17, at 10:19 a.m. the DON completed an assessment of the resident's skin condition. The DON stated the left ischial tuberosity had superficial skin loss over the previously identified Stage I on 4/11/17. The DON stated although she noted the Stage I pressure ulcer, she did not

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	00740	A. BUILDING: ____ B. WING ____	04/14/2017

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EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423**

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notify the physician or complete any related paperwork at that time. R35 moaned, tightened her jaw and had furrowed brows when assisted to turn to her left side. The DON then observed the left heel, which she stated was a suspected deep tissue injury measuring 1 cm x 1 cm x 1 cm. R35 reported the area was painful to touch.

On 4/12/17, at 1:44 p.m. nurse practitioner (NP)-A stated she was new to the facility and unfamiliar with R35. NP-A stated it was an expectation the staff would contact the NP with new skin alterations, but had not been informed of any problems with R35's skin since she began seeing the resident on 4/3/17. If skin alterations were observed, NP-A would institute orders to off load pressure and implement pressure relieving interventions. If a new wound had developed, she would potentially order a Mepilex dressing.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A. He reported he saw R35 for the first time on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. MD-A expected to be notified of significant decline in wounds. It was also expected daily dressing changes would be performed on R35's right ankle. MD-A reported R35 had a Stage IV ankle ulcer, and would have increased in size/severity without appropriate dressing changes. It was MD-A's impression the staff were elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks.

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2 265	Continued From page 5 On 4/13/17, at 12:30 p.m. the DON stated her expectation was the nurse should immediately notify the NP when the skin alteration was observed, as the NP ultimately oversaw care for R35. The DON stated R35 experienced pain with dressing changes. The facility's 4/21/14, Chalet Living and Rehab Wound Care Program policy and procedure indicated the facility would "initiate wound care treatment upon identification of the wound with physician's order and to refer to the wound care specialist in a timely fashion." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop policies and procedures to ensure each resident's physician and representative are promptly notified of all changes in condition and/or changes in treatments. The DON or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance and share those results with the QA/QO committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty One (21) Days.	2 265		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's	2 302		5/25/17

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disease or related disorders, whether in a segregated or general unit, the facility's direct care staff
and their supervisors must be trained in dementia care.

(b) Areas of required training include:
(1) an explanation of Alzheimer's disease and related disorders;
(2) assistance with activities of daily living;
(3) problem solving with challenging behaviors; and
(4) communication skills.
(c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered.
(d) The facility shall document compliance with this section.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure consumers were provided information regarding dementia training as required. In addition, the facility failed to provide dementia and related behavioral training to all employees annually. This had the potential to affect all 69 residents and their representatives.

Corrected

Findings include:

During a review of the facility's Alzheimer's training program, there was no evidence consumers (residents and their representatives) were provided a description of the facilitiy's Alzheimer's training program, categories of

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employees trained, frequency of training and the basic topics covered.

During an interview on 4/11/17, at 9:28 a.m. the licensed social worker (LSW) stated she had been providing Alzheimer's and dementia training to staff for the past two to three years. The LSW explained the facility is under new ownership and she only provided the training to new staff at the time of their orientation to the facility. The LSW and director of social services (DSS) verified the last annual staff training on Alzheimer's/dementia had been on 12/2/15.

On 4/11/17, at approximately 11:00 a.m. the executive director (ED) and DSS provided the surveyor with the facility admission packet they gave to all newly admitted residents and their representatives. The admission packet did not include an overview of the facility's Alzheimer's/dementia training.

During an interview on 4/12/17, at 8:33 a.m. the DSS verified the facility did not have documentation showing consumers were provided in writing or in electronic form a description of the Alzheimer's training program, categories of employees trained, frequency of training and the basic topics covered.

The facility stated they have no policy on Alzheimer's/dementia training.

SUGGESTED METHOD OF CORRECTION:
The ED, DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information and provide annual training to all staff. The ED, DON or designee could educate staff about this requirement and conduct audits to

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2 302	Continued From page 8 ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop a care plan for 1 of 1 residents reviewed (R35) related to pressure ulcers. Findings include: R35's care plan dated 3/21/17, identified that R35 had actual alteration of skin integrity due to being cognitively impaired, assistance with ADLs, neurodermatitis, and had scratches/wounds on both lower extremities, left buttock, shoulder, and chest. R35's care plan directed facility staff to assist with repositioning frequently in bed to avoid laying on open areas. The care plan directed staff to ensure that proper pressure reducing device is in the chair and positioned correctly before transferring R35 to wheelchair. Further, the care	2 560	Corrected	5/25/17

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plan directed staff to "assist with repositioning in bed to avoid laying on open areas frequently". The care plan did not address R35's suspected deep tissue injury to the left heel, unstageable ulcer to right heel, right inner ankle press ulcer, and right great toe wound. The care plan did not direct facility staff how often R35 needed to be turned/repositioned or what pressure relieving devices were to be in place.

R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 had moderate cognitive impairment and had diagnoses including rheumatoid arthritis (known to contribute to pain), dementia and anxiety. R35 required extensive assistance with activities of daily living (ADLs). R35 did not have any pressure ulcers but was at risk. The MDS indicated a formal assessment tool and a clinical assessment were completed to determine R35's pressure ulcer risk.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations due to: weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. Although a pressure ulcer was not identified on the CAA it was noted R35 was at risk for pressure ulcers due to immobility and incontinence, and required a special mattress or seat cushion to reduce or relieve pressure.

R35 was observed continuously on 4/10/17, from 1:58 p.m. to 4:15 p.m. R35 remained in wheelchair without a change in positioning or assistance offered for at least 2 hours, 17 minutes.

On 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to

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3:19 p.m. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes. NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F and NA-E changed the incontinent brief and provided peri-care. NA-F described R35's brief as moderately wet. The DON then assessed the resident's skin condition. The DON described R35's skin as: right upper buttock was open and excoriated from moisture, left ischial tuberosity (hip) was boggy and non-blanchable. The left bottom buttock was reddened but blanched, right ischial tuberosity was blanchable, right lower extremity has sores and scabs which had Tegaderm dressings, right medial ankle pressure ulcer and treatment to be done at bedtime. R35's Prevalon boot was soiled with blood and wound drainage which was confirmed by the DON. R35's wheelchair cushion was approximately one half inch in height, and the DON confirmed it "does not feel adequate." NA-F reported she did not know the last time R35 had been changed or repositioned.

The next day on 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON was unaware why care had not provided care for R35. The DON stated R35 sometimes resisted care. The DON stated she felt staffing challenges contributed to issues with timely care for R35. The surveyor informed the DON of serious concerns regarding R35 and she responded, "Me too." The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an assessment of the resident's skin condition. The DON changed the incontinent brief

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and provided peri-care. The DON did not know the last time R35 was last changed or repositioned.

During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition, as she was unable to move herself.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A reported he had first seen R35 on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was Dr. was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. It was MD-A's impression the staff were elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks.

NA-A stated on 4/13/17, at 8:17 a.m. R35 was to be checked on every 15-20 minutes. Staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.

On 4/13/17, at 8:28 a.m. LPN-D reported it was expected the NAs would check on the resident because of her skin issues. LPN-D believed the right hip area was due to pressure, and the other wounds were from scratching and picking at herself.

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On 4/13/17, at 10:56 a.m. NA-G was unsure if R35 had wounds on her feet, or whether any changes had been made to her care plan in the last week.

However, on 4/13/17, at 11:05 a.m. NA-H reported R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's heels or feet.

On 4/13/17, at 12:30 p.m. the DON stated that the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. Prior to the survey entrance the DON said she had not thought of putting a different mattress on R35's bed. The DON expected staff to reposition, check and change R35 at least every two hours. The DON expected nurses to monitor R35's skin every shift and assess once weekly on bath day, and to document findings. In addition, it was expected a comprehensive skin assessment would be completed when a new area was found. The DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated she felt it should have been.

The facility's policy and procedure titled "Repositioning and Turning" which was not dated, indicated "that residents are turned/positioned in accordance with the plan of care to prevent skin breakdown." The policy further indicated that residents who are unable to

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reposition themselves will be turned and repositioned every one to two hours in accordance with their needs, using a written care plan as determined by licensed staff. The standards of the policy indicated the Charge Nurse was responsible for incorporating the plan, approaches, and goal on the care plan.

A second policy titled Chalet Living and Rehab "Wound Care Program" dated 4/21/14, indicated the Braden Scale had to be completed upon resident's admission and weekly for the first 4 weeks of admission to determine the score and the level of risk for skin breakdown. Then, the risk factor(s), potential cause(s) and interventions should be reviewed and addressed on the care plan. The policy indicated when a resident is in bed or wheel chair they should be turned/reposition at least every two hours or as indicated on the resident's care plan. Lastly, the policy stated the care plan shall be evaluated and revised based on the resident's response to treatment, goals, and outcomes.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could develop policies and procedures to ensure individualized comprehensive care plans are developed for residents. The director of nursing or designee could educate all appropriate staff on these systems. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance and share those results with the QA/QI committee for further guidance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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2 565	Continued From page 14	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow careplans for 1 of 1 residents (R22) reviewed for hearing and for 1 of 13 residents (R49) needing meal assistance. In addition, the facility failed to follow a careplan for toileting assistance for 1 of 3 residents (R35) reviewed for activities of daily living (ADLs). Findings include: R22 was not consistently provided his hearing aide. On 4/11/17, at 2:05 p.m. Family Member (FM)-C stated R22 did not have his hearing aide in his ear at 1 p.m. today and stated that the nurse she talked to today had not known that R22 was missing his left hearing aide. FM-C stated R22's left hearing aide had been missing for a few months and that the administrator had stated he would look into it and had not yet gotten back to her. R22's annual Minimum Data Set (MDS) indicated R22's cognition was moderately impaired, hearing indicated minimal difficulty, and wears hearing aides. R22's same annual MDS indicated R22 makes self understood and understands. The annual MDS also indicated R22 needed staff assistance with dressing and personal hygiene.	2 565	Corrected	5/25/17

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R22's 1/31/17, Care Area Assessment indicated R22 has impaired hearing and wears hearing aides.

R22's 3/24/16, careplan indicated "Check for wax in [R22s] ears...Place hearing aids in both ears. Make sure hearing aids are working...clean hearing aids [in the top drawer of med cart] every night shift every Thursday" R22's careplan dated 3/30/17, indicated, "Hearing Aids: Insert Hearing Aids in Both Ears Every Morning"
On 4/11/17, at 2:05 p.m. R22 was observed lying on top of his bed eyes closed with no hearing aides in ears observed.

On 4/11/17, at 2:36 p.m. nursing assistant (NA)-P stated R22 had just come to this unit 2-3 weeks ago and NA-N had gotten R22 up today. NA-P stated R22's hearing aide was kept in the nursing cart.

The following morning at 9:15 a.m. R22 was pushed in his wheelchair (w/c) NA-K up to the table in the dining room. No hearing aides were observed in R22's ears. R22 started taking a few bites of his french toast and then without trying the bacon, oatmeal and liquids started wheeling himself out of the dining room into the hall next to his room door. Surveyor asked R22 a question and R22 just looked back at surveyor and did not speak. Surveyor asked NA-P if R22 wore hearing aides and NA-P said yes. NA-P then asked R22 if he could hear her and R22 answered "barely". NA-P stated she had not helped R22 up this morning that NA-K had assisted R22. NA-P stated she would tell the nurse R22 did not have his hearing aide in this morning. NA-P wheeled R22 back up to the dining room table and asked him if he wanted juice and poured him a glass

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2 565	Continued From page 16 and R22 took a drink. Registered nurse (RN)-F brought R22 his hearing aide for his right ear and placed in his ear and resident stated he could now hear. R22 then proceeded to take bites of his food. Half hour later at 9:34 a.m. RN-F stated R22 had moved up to this unit from another floor and had lost his hearing aide before coming to this unit. RN-F stated R22 now only had one hearing aide and that family was aware. On 4/12/17, at 10:23 a.m. RN-F stated there was a standing order for ear drops and flushing which was used for R22 in January. RN-F stated she checked residents' ears every three months for wax build up and if wax build up was observed ear drops would be place for three days and then on the fourth day would flush the ears. RN-F verified on R22's treatment administration record (TAR) that ear drops had been administered to R22 on 1/28/17, and 1/30/17, and that on 1/29/17, ear drops were not given as unavailable. RN-F also verified that the TAR did not indicate an ear flush to remove wax had been completed. RN-F stated the nurses know that the flush comes after the ear drops on the fourth day. RN-F stated she did not know why the ear drops would have not been available the 2nd day as there was house stock. RN-F verified on R22's physician order that there was an order on 1/27/17, for ear drops to be started for flush could be completed by nurse practitioner (NP) on 1/30/17. RN-F stated the nurse working on 1/30/17, should have placed ear drops for R22 since 1/28/17, had been missed. RN-F stated the NP should have been notified and verified no documentation in the progress notes indicated that the NP had been notified. RN-F stated NP fax their notes to the facility. RN-F stated she would look at R22's ears	2 565		

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today and if had wax build up she would follow the standing order and start ear drops for R22 and notify NP and document this in the progress notes. RN-F stated NA-P had told her this morning R22 needed his hearing aide put in but had been busy giving out medications at the time. RN-F stated R22 responded to her when she called him by the name he preferred and not his given name.

On 4/13/17, at 9:57 a.m. R22 was observed lying on top of his bed eyes closed with no hearing aide in right ear.

On 4/13/17, at 10:03 A.M. Social Services Director (SS) stated he was aware of R22's hearing aide missing a couple of weeks ago when FM-C had told him and FM-B had told him that the hearing aide had been missing quite awhile. SS stated he referred FM-C to the administrator but thought licensed social worker (LSW)-A had already done that.

On 4/13/17, at 11:01 a.m. the assistant director of nursing (ADON) who also was the manager of R22's unit stated she had not been aware of R22's hearing aide not being in his ear and stated it was the nurse's responsibility as the hearing aide was locked in the cart. ADON stated ear drops and flush were a standing order and she expected nursing staff to follow the orders and if for some reason can not complete a treatment should pass on to the next nurse and expected the nurse to complete it. ADON stated R22's ear drops should have been given on the fourth day for not being completed on the second day. ADON also stated the flush should have been written on the TAR and documented in the progress notes that the treatment was completed and the results. ADON stated R22 had come up

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to her unit from the 2nd floor and had remember talking about his missing hearing aide in an interdisciplinary team meeting. ADON stated the facility had replaced another resident's hearing aides last fall because of new regulations. ADON stated discussion had been about if resident puts in the hearing aide in or if the staff does or staff drops them. ADON stated nurses should put in residents' hearing aides in at 8 a.m. or upon getting up. ADON stated it would benefit the residents to have the hearing aides in. ADON stated she had talked to FM-C about a week ago and she had not mentioned to her about staff not putting in R22's hearings aides.

Nursing Progress Note dated 3/15/17, indicated, "Resident had none of the hearing aids in this evening, Resident not able to articulate the whereabouts of the hearing aids. writer searched in the room and unable to relocate them."

Review of NP's January 2017 notes did not indicate an ear flush had been completed for R22. NP note dated 3/14/17, indicated "HL [hearing loss], bilateral [R22] Wears bilateral hearing aids. Was only wearing one today during visit."

R22's nursing progress note dated 4/12/17, written by RN-F indicated R22's ears were inspected for ear wax with wax built up in the right ear and started ear drops for right ear for three days and irrigation of ear to follow on the fourth day.

On 4/13/17, at 2:22 p.m. director of nursing (DON) stated R22's family had asked her to clean out R22's ears and she had asked the NP to do this and to her knowledge thought it had been done. DON stated it should be documented in the

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NP notes. DON stated the family was not happy with the 3N unit since R22 being recently moved up there and stated she would be doing some education the staff the importance of hearing aid placement as since if you can not hear you would be upset. DON stated the hearing aids should be provided in morning cares and no later than when residents come out to breakfast.

R49 was observed on 4/11/17, at 8:34 a.m. sitting at a table in the 3N dining room. Couple minutes later R49 was served a plate of food on the table. R49's plate had a pancake, a sausage patty and scrambled eggs. R49 proceeded to take bites of her scrambled eggs with a spoon in her right hand. R49 picked up her uncut pancake and proceeded to take bites of her pancake with her fingers and then picked up her uncut sausage patty with her hands and take bites of the sausage patty with her fingers.

At 8:45 a.m. NA-P sat down at R49's table and helped another resident to eat. No assistance was provided to R49. Staff was present in the dining room and did not offer to assist R49.

The following morning on 4/12/17, at 8:25 a.m. R49 was observed sitting at the table in the dining room on 3N. A couple minutes later NA-K set a plate of food in front of R49 on the table. NA-K cut up R49's french toast and poured maple syrup. NA-K quickly cut couple times into the sausage patty without cutting through into smaller sections and walked away from table. The sausage patty was observed to have two marks in it but not cut apart. R49 picked up her fork in her right hand stabbing at the sausage patty and then unable to cut apart picked up the sausage patty with her left hand and pulled off a piece and put in her mouth. R49 holding bacon with left

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hand and fork in right hand breaking bacon into pieces. NA-K had not asked R49 if she wanted her bacon cut up into smaller pieces, only asked her about the sausage and french toast which she said yes she would like cut up.

At 8:34 a.m. NA-P sat down by another resident at the same table where R49 sat. R49 then proceeded to attempt to cut up her sausage patty up with her fork and after many attempts picked up the sausage with her left hand and took bites of. NA-K walked up to R49 and asked if R49 wanted anything more to eat and NA-K proceeded to pour apple juice and then walked away. R49 took some bites with fork in her right hand of scrambled eggs and dropped some pieces of egg on her towel and picked up pieces and set down on plate. R49 ate all her food and beverages.

R49's quarterly Minimum Data Set dated 3/1/17, indicated R49 needed limited staff assistance for eating and also indicating R49 was highly involved in activity and staff provided guidance of maneuvering of limbs or other non wt-bearing assistance.

R49's current careplan indicated staff were to assist for meal set-up, cut food into small pieces, and provide supervision with all meals. The same careplan also indicated staff were to provide as much assistance as needed with meals.

On 4/13/17, at 10:33 a.m. the assistant director of nursing (ADON) stated she did not consider eating with fingers dignified. ADON stated staff should have asked R49 if she wanted her food cut up and staff were expected to follow careplans because that is how the staff know of how to provide care for their residents.

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2 565	Continued From page 21 Policy provided by the facility Care Plans dated July 2015, indicated "... Reflects the resident/resident representative input and goals for healthcare" R35 was not offered toileting assistance according to her plan of care. R35's care plan dated 3/21/17, identified R35 needed assist of two staff members for toileting. R35 was to be checked at least every two hours for incontinence. The care plan directed staff to monitor for signs of incontinence decline and to offer/encourage the toilet upon rising, before and/or after meals, and at bedtime and during night rounds. Further, the care plan directed staff to assist with perineal hygiene after toileting, change incontinent briefs when soiled and to check brief for incontinence with rounding. R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 required extensive assistance with activities of daily living (ADLs). R35 was not on a toileting program, however, was frequently incontinent of bladder and bowel. R35's Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs. The CAA further identified R35 had chronic health issues/conditions, such as incontinence or pain that resulted in reduced activity participation. The CAA identified that R35 had urinary urgency and needed assistance in toileting which contributed to incontinence. The CAA also identified that R35 was offered toileting upon rising, after meals, at bedtime, and on rounds. R35 wore an incontinence brief to protect her skin and provide dignity. R35 was continuously observed on 4/10/17, from 1:58 p.m. to 4:15 p.m. At 4:15 p.m. R35 remained	2 565		

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2 565	Continued From page 22 in wheelchair without a change in positioning or assistance offered for at least 2 hours, 17 minutes. On 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to 3:19 p.m. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes. NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F described R35's brief as moderately wet. NA-F and NA-E changed R35's pants, as the ones she had been wearing were wet wet with urine. R35's wheelchair cushion was saturated with a circular area of urine and smelled strongly of urine. NA-F confirmed the cushion was wet with urine, and attempted to clean it with a Sani Wipe. NA-F reported she did not know the last time R35 had been changed or repositioned. On 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. The room had a strong urine odor. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON was unaware why care had not provided care for R35. The DON stated she felt staffing challenges contributed to the issues with timely care for R35. The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and changed the incontinent brief and provided peri-care. The DON described R35's brief as saturated with dark colored pungent smelling urine. The DON did not know the last time R35 was last changed or repositioned. The DON expected staff to follow the care plan and to change and reposition R35 at least every two hours. On 4/11/17, at 3:20 p.m. NA-F explained R35 did	2 565		

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not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition, as she was unable to move herself. NA-F stated R35 requested to use the toilet at times, but was unable to bear weight, therefore, her incontinence brief was changed in bed.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A who reported he had first seen R35 on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A stated he expected the resident would be repositioned out of her wheelchair at least every two hours.

NA-A stated on 4/13/17, at 8:17 a.m. staff was supposed to check on R35 every 15-20 minutes. NA-A was unaware if there had been changes to R35's care plan.

On 4/13/17, at 10:56 a.m. NA-G stated she had repositioned and changed R35's wet incontinence brief at 7:00 a.m. NA-G stated the night shift had changed R35 at 5:00 a.m. R35 stayed in bed after incontinence care, and was reapproached at 10:00 a.m. and 10:35 a.m. to offer repositioning, but said R35 had refused.

However, on 4/13/17, at 11:05 a.m. NA-H reported she had changed R35's incontinence brief at 7:30 a.m. and the resident had been incontinent of both bowel and bladder. NA-H was unsure when R35 had been changed prior to that time. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program.

On 4/13/17, at 12:30 p.m. the DON stated the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON

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2 565	Continued From page 24 expected staff to reposition, check and change R35 at least every two hours. The care tracker was a tool for NAs to use to know R35's plan of care which indicated R35 was continent of bowel. The care tracker directed staff to monitor for urgency and give suitable time in the bathroom. R35 was frequently incontinent of bladder and to offer toileting with rounds. Staff was directed to offer/encourage to use toilet upon rising, before and/or after meals at bedtime and during night rounds. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop systems to ensure the comprehensive care plan is followed. The director of nursing or designee could educate all appropriate staff on the utilization of the plan of care. The DON or designee could develop systems to monitor for ongoing compliance and share those results with the QA/QI committee for additional recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.	2 800		5/25/17

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This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure sufficient staffing was provided to meet the needs of residents regarding repositioning, pressure ulcer care, check and change programs, pain management, and assistance with ADLS. This deficient practice caused harm to R35. This had the potential to affect all 69 residents residing in the facility.

Corrected

Findings include:

R86's family member (FM)-E when interviewed on 4/11/17, at 9:55 a.m. stated, "I come up here (3N) every other day after work, I think those residents here need activities." FM-E stated, "Since the new owners there is less staff, not enough nursing assistants (NAs)."

On 4/11/17, at 10:15 a.m. FM-C stated R22 had moved up to 3N from the second floor. FM-C stated on the second floor staff did not always take R22 to the bathroom so the family would help assist him, staff seemed to put the same dirty clothes on him, and he had long toe nails. FM-C stated FM-B would lay out different clean clothes for R22 to wear the next day but staff would have the same dirty clothes on him. FM-C stated staff do not clean out his ears, and staff do not trim R22's nails. Staff do not always place his hearing aid in. FM-C stated they were still waiting to hear from the administrator about R22's missing hearing aid.

On 4/11/17, at 1:41 p.m. FM-F stated his family member fell about of bed last week and had an

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abrasion. FM-F stated apparently it was someone new working on the night shift. FM-F stated there used to be a full time social worker here that stayed on the unit most of the time and more games and activities happened, but now activities have decreased on the unit.

R89's FM-E on 4/11/17, at 1:52 p.m. stated on a Tuesday about three weeks ago she had waited 35 minutes for staff to answer her family member's call light and there was no staff in sight. FM-E found NA-N and he helped her family member to the bathroom. His bed had been soaked and "reeked of urine". NA-N told FM-E he was the only NA who showed up for work that day. FM-E stated that working with one NA happens about four times a week here. FM-E stated she found the call light stuck approximately 10 inches under the mattress a couple of times when coming to visit R89. FM-E stated she found R89 on a wet bed but a dry pad a couple of times.

R16 on 4/10/17, at 2:36 p.m. stated, "I have to wait 30 minutes, up to an hour for my night medication." R16's quarterly Minimum Data Set (MDS) dated 2/14/17, indicated R16's cognition was intact.

R27 on 4/10/17, at 2:39 p.m. stated, "After three times the staff do not come in anymore. No one here cares." R27's quarterly MDS dated 3/15/17, indicated R27's cognition was intact.

R47 stated on 4/10/17, at 4:18 p.m. stated, "They are so short on help, I wake up in the morning and have to wait an hour for help to get me dressed." R47 further stated "When you put your call light on you have to wait about 15 minutes, staff have told me they are short staffed." R47's quarterly MDS dated 12/28/17, indicated R47's

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cognition was intact.

R87 on 4/10/17, at 4:30 p.m. stated, "We are short of NAs, our nurses are leaving like flies." R87 stated they had a resident council meeting today and the administrator did not want to spend any money. The new SS is taking over today. R87's quarterly MDS dated 1/11/17, indicated R87's cognition was impaired.

R53 on 4/10/17, at 5:36 p.m. stated, "We are always understaffed, evening shift is the toughest and nights are short staffed also." R53 stated he has had to wait a long time for pain medications. R53's annual MDS dated 3/7/17, indicated R53's cognition was intact.

R67 on 4/10/17, at 6:15 p.m. stated, "I will put my call light on and have to wait for one half hour or more for some one to come in." R67 also stated they had been short of staff lately and there had only been one NA on the floor since the new ownership. R67's quarterly MDS dated 1/25/17, indicated R67's cognition was intact.

R89 on 4/11/17, at 9:18 a.m. stated, "I have to wait a long time when I put my call light on, and staff walk in here and help my roommate and when they are done with him I will say, Hey that was me that put on the call light. Four times they have just poked in their head and just left the room when I had my call light on, even when I was sitting on the edge of the bed watching traffic." R89's quarterly MDS dated 3/15/17, indicated R89's cognition was impaired.

On 4/10/17, at 2:27 p.m. NA-K stated this last weekend there was one one NA on 3S for 17 residents and one NA can not help 17 residents get up in the morning. NA-K stated this last

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weekend there was only one NA on 2nd floor as well.
RN-A standing nearby stated the medical insurance was not good here and staff was working on other jobs. The facility was sold and they were cutting activities and housekeeping and staff did not feel it was fair to the residents. RN-A stated they are very short staffed here. There was only one person in the kitchen today out of four. RN-A stated staffing was getting worse and more often short staffed. RN-A stated one night there had been only one person, a nurse, on the whole floor. There were no NAs, just the nurse to pass the medications and provide cares for 17 residents.

On 4/11/17, at 1:25 p.m. housekeeper (HK)-C stated there were only two housekeepers today for the whole building and it's hard to keep everything up on the three resident floors and the basement room. HK-C stated it was difficult to keep the basement bathrooms' clean. HK-C stated they had talked to management about it but they were not doing anything but cutting down the janitor hours. HK-C stated there was no housekeeping staff to clean the dining rooms in the evenings and the resident room floors needed waxing. HK-C stated the facility was trying to cut down because of money.

On 4/12/17, at 8:08 a.m. RN-F stated the facility was short of staff. RN-F stated medical insurance went up a lot recently and RN-F was shopping for a new job. RN-F stated staff were mandated to stay after they had already worked an eight hour shift because they can not fill all the shifts. RN-F stated they were also short of NAs. RN-F stated sometimes only one NA works instead of the two NAs needed per shift.

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On 4/12/17, at 8:44 a.m. NA-P stated two NAs were needed each shift for the 3N unit. NA-P stated sometimes they only worked with one NA. NA-P stated dietary did not pass out the residents meals, the NAs did and there were residents who needed meal assistance.

On 4/12/17, at 9:54 a.m. HK-C stated the facility was short of staff in every department. HK-C stated a lot of the staff were looking for another job since staff found out in February the cost of medical insurance increased so much.

On 4/12/17, at 2:00 p.m. maintenance director (MD) stated he recently became the director and had worked at the facility for three years in maintenance. MD stated the director recently left employment and the facility was not planning on replacing him. MD stated they had a list of things to do and had to prioritize what to complete as they often got pulled off tasks. MD stated he was in charge of four departments: laundry, housekeeping, janitorial and maintenance. MD stated last week he had to fill in for staff absences in each of the departments. MD stated they had been trying to update the facility this last year as well as keeping up with maintenance and repairs but they could not get to everything.

On 4/13/17, at 9:52 a.m. RN-F stated they picked up today instead of being mandated to double.

On 4/12/17, at 11:56 a.m. the administrator confirmed that this last Saturday night there was no NA working on the floor and only one nurse (RN-B) working on first floor with 13 residents. The administrator was asked how many NAs were working on the other floors that night. The staffing coordinator (SC) stated this last pay period had forty plus openings for nursing

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assistants and forty plus openings for nurses that they were unable to fill.

Five minutes later at 12:01 p.m. administrator came back and stated it was Monday night and not Saturday night when there was no NA on first floor for the night shift. The administrator further stated on Monday night there was one nurse and only one NA on second floor and one nurse and one NA on third floor Monday overnight. The administrator stated there should have been two NAs overnight on second floor, two NAs on third floor, and one NA on first floor. The administrator stated the facility could not use float pool or agency as of 3/31/17, when the new ownership was in place.

On 4/13/17, at 10:22 a.m. the assistant director of nursing (ADON) stated she worked at the facility for 2 1/2 years with 1 and a half years as the nurse manager for the transitional care unit (TCU). The ADON stated it had been 2-3 weeks now since she had been asked to also be the nurse manager for the 3N unit. It was when the new owners revamped and she was now called the ADON instead of nurse manger. The ADON stated the facility thinks it's manageable for her to be nurse manager of 3N and the TCU. The ADON stated the TCU can be very busy. The ADON stated the DON was the nurse manager for the other three units of long term care. The ADON stated she did not know the residents of 3N very well yet. The ADON stated since having new ownership the facility had been working with only one NA and not the two NAs they usually had. The ADON stated the facility can no longer use the float pool/agency. They had been utilizing agency for three full time positions before the change of ownership. The ADON stated she was interviewing staff about the residents on the 3N

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unit because she did not know the residents yet. The ADON stated 3N presently has 14 residents on 3N and TCU number of residents vary, currently having 13 residents. The ADON stated the TCU is very time consuming.

On 4/13/17, at 2:22 p.m. the director of nursing (DON) stated she had been DON for two weeks. The DON stated she had previously been the nurse manager for the two units on second floor. The DON stated the ADON was now the nurse manager for TCU. The DON stated RN-G had been the nurse manager of two units on the third floor but had left employment with the facility in 2/17. The previous DON had left employment 3/27/17. The DON stated RN-E had become the new ADON when she became the new DON. The DON stated the facility used to have someone in charge of education. She stated the previous educator had left in 3/17 and she would be responsible for completing training with the staff. The DON stated the ADON was supposed to be doing all nurse management duties for the whole facility, but did not agree with those responsibilities. She stated the ADON only wanted to do three units, the TCU units she had been previously doing and the one 3N unit. The DON added the ADON was leaving employment with the facility next week. The DON stated residents in the long term care units on second floor come to her with their concerns and the nurses on the floor help complete the resident assessments. The DON stated she is going to have two ADON's with nurse manager responsibilities. The DON stated the consultant is going to help hire an ADON.

R60
During an family interview on 4/10/17, at 2:02 p.m. R60's family member (FM)-A stated she

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noticed some staff issues in the facility. FM-A explained R60 required 2 nursing assistants (NA) and the use of a hoyer lift to transfer. R60 relied on transportation to and from appointments using metro mobility. However metro mobility will only wait 5-10 minutes then they will leave with or without you. FM-A stated that on more then one day the floor is only staffed with one NA so she had to be the second person to help transfer R60 with the hoyer lift or they would miss there ride with metro mobility. FM-A also stated that new staff have not been trained on how to properly use a hoyer lift because they were put on the floor so fast due to the shortage. "I feel sorry for the residents who can't speak for themselves."

During a meal observation on 4/10/17, at 5:55 p.m. residents were served a plain hamburger with no condiments. The only staff serving the residents was the nurse, however three residents requested ketchup, but only one resident was able to get up on his own and get a packet out of the refrigerator. The other two residents finished their hamburger without getting ketchup. The nurse was observed helping another resident onto the elevator and left the floor in the elevator. Four residents sat at the table with no meal for them to eat. At 6:06 p.m. the two NAs entered the dining room and brought the four resident's their meals.

On 4/11/17, at 9:20 a.m. NA-N stated when the State is here management scheduled two NAs but usually there was only one NA. "If my phone rings I don't answerer it because I know the [facility] wants me to pick up a shift and I will have to work the floor all alone."

On 4/12/17, at 7:34 a.m. NA-O stated she was a regular on the floor and sometimes there was

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only one NA when there should be two, "it's hard to get the work done on time." NA-O further stated the licensed nursing staff does not help to answer call lights. NA-O explained just last Friday she was the only NA on the floor and NA-L was being trained in when management pulled the person training her to another floor so she did not get the training she needed.

On 4/12/17, at 10:12 a.m. the DON explained that staffing challenges contributed to the lack of timely cares on R35. The DON stated the facility attempted a staff to resident ratio of 10:1, however, felt the second floor suffered the most due to having more residents with higher acuity. Although, the facility staffs the more experienced NAs on the second floor they are slower. The DON was made aware of serious concern due to lack of care for R35 and she responded "me too." The DON stated the director of nursing role and charge nurse duties are difficult to do. Further, she stated she had talked to some of the floor nurses to assist with the charge nurse duties and are in the process of hiring. The DON stated she cannot do both roles but at the time of survey she was "unable to talk to their corporation due to Pass-Over Holiday." The DON mentioned that she had not been able to put R35's wound measurements in the record as she had not gotten to them yet.

On 4/12/17, at 9:14 a.m. HUC-A stated her role is to schedule rides, appointments, referrals, and coordinate care between doctors for the residents. She further explained that she was usually pulled from that role one to three times per week to be a medication aid throughout the building depending on staffing "if they are short". HUC-A stated it depends on the day if she has enough time to get both jobs completed. HUC-A

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explained she does get pulled away from passing medications to complete medical record responsibilities. HUC-A stated the facility is usually short due to call ins which are handled by staffing coordinator or the night supervisor and are usually 25% successful at filling a shift if that occurs. HUC-A stated she had heard residents and staff complaining of being short staffed. Further, explained the NAs complained about not having enough time to get cares done and to meet the needs of the residents. HUC-A felt the DON and administrator know about the short staffing and had in fact discussed with the DON last week. HUC-A stated the facility is working on hiring people and sees new employees start in orientation. HUC-A explained new employees stay for approximately a month and then leave because the job is too hard. HUC-A is unsure if facility had done anything additional to continued hiring like adds, job fairs, etc.

On 4/12/17, at 1:44 p.m. NP-A stated a situation occurred last week which prompted her to have a conversation with the DON and her concern for staffing. NP-A informed the DON she would partner with her for education for the nursing department, NAs, and proper notification. NP-A stated the facility had large staff turn over with the recent change of ownership and the employees cannot afford the insurance so they left.

On 4/12/17, at 2:43 p.m. NA-A stated that she usually worked on the third floor but today was pulled down to the second floor due to short staff. There is supposed to be three NAs working on the second floor but one left at 10:00 a.m. due to an emergency. This staff was not replaced and there were two NAs for all of the residents on the second floor. She stated that today she will have to stay overtime to chart.

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Registered nurse (RN)-D, on 4/12/17, at 10:48 a.m. she stated there was not adequate staffing so had a hard time finishing work. She stated the facility had trouble with staff retention. On 4/12/17, RN-D covered two medication carts and 26 residents during her shift. She stated that she was overwhelmed that day. RN-D stated there were two residents on the second floor that were supposed to get out of bed daily but this did not happen every day when there was not enough staff.

R35's Minimum Data Set (MDS) dated 2/7/17, identified R35 was moderately cognitively impaired.

On 4/11/17, at 8:17 a.m. writer heard R35 calling out "help me" from behind a closed door without staff in the area. Writer advised Health Unit Coordinator (HUC)-A R35 was calling out "help me" continuously from her room with door closed. HUC-A opened door revealing R35 in her bed laying partially on her right side with face contorted and still calling out "help me". When R35 saw HUC-A she stated "where were you? I have been calling for a half hour and I am scared. I thought you forgot I was here."

On 4/11/17, at 8:20 a.m. during an interview with HUC-A she stated when she walked in R35's room she was facing away from her call light button and could not reach it. HUC-A stated R35 said she had been calling for a long while and when no one came she was scared. The call light was hanging from a grab bar attached to R35's bed and she probably could not reach it.

On 4/11/17, at 8:23 a.m. during an interview with R35 she stated she had been yelling help for 1/2

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hour before someone came. R35 stated she was scared because she thought the staff forgot where she was and she wanted to get up but could not reach the call light so she started calling out. R35 further stated the staff never responded when she calls for them or when she presses the call light.

On 4/11/17, at 8:29 a.m. Nursing Assistant (NA)-A stated sometimes there is not enough staff working so it makes double work the rest of the staff. We are short today. It takes a long time to get all the residents up in the morning and dressed and there are only two of us on second floor today. I think we need more staff because we can't take care of the residents like we are supposed to. Call lights can take a long time to get to and residents stated they do not get their breakfast on time or they had to wait a long time to get on the bedpan.

On 4/12/17, at 10:10 a.m. the executive director stated the facility was sold as of 3/6/17, and they created staffing ladders per diem per patient day. We did not factor acuity into it. There is a per diem for nurses and NA's. We quit using agency staff on 3/31/17, and they had previously accounted for about 20% of our staffing for nurses and NA's. We did not know we were not going to be able to use pool staff until one week before the sale of the facility.
On 4/12/17, at 10:30 a.m. the staffing coordinator stated they were not able to fill the staffing needs for the facility at this time. The facility had 40 open NA shifts and 49 open nursing shifts the last two weeks. If an employee called in sick the facility instituted mandatory overtime if we determined the number of staff working could not provide safe care to the residents. We have had to mandate overtime and have had a lot of staff

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working double shifts. We have not been able to staff the shifts adequately the last 2 weeks. Sometimes there was only one NA on the 3rd floor on the night shift. We had a NA call in sick on 2nd floor days and evenings so we were short over the weekend. On 4/8/17, we could not fill 3 NA day shift positions in the facility. On 4/7/17, we were short two NA 's on night shift on TCU and 3N. There was a NA who did not call in sick or show up on TCU for their evening shift but I know another nurse stayed even though it is not indicated on the printed schedule. Some days our staffing is good some days not. We have had complaints everyday from NA's and nurses regarding the staffing shortage and having to work more shifts and longer hours. A few residents have complained about staffing also. On 4/12/17, at 8:28 a.m. RN-B stated staffing was frustrating. There are a lot of call ins they are unable to replace. The staff left working are frustrated when someone calls in sick because then they have to work harder and longer. Some irresponsible staff are calling in a lot which makes a lot of work for the rest of the staff. If it is unsafe for the residents the facility mandates overtime for nursing staff. This morning was mandated to stay over from night shift because it would have been difficult for just the day nurse to give all the medications on the second floor. When we are short staffed the residents know and they don't ask for things they may usually ask for. Call lights are not answered as quickly and residents state they have had to wait.

On 4/12/17, at 10:06 a.m. NA-B stated this morning there was only one scheduled nurse which is not enough for this many residents. In order to do things well for the residents they needed three NA's working on both the day and evening shifts. NA-B further stated they have had

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to work short for the last few weeks.

On 4/12/17, at 3:08 p.m. the executive director stated the facility was currently accepting admissions.

On 4/13/17, at 8:23 a.m. the DON stated staffing was a concern. When the facility was sold we were told we were not allowed to use float pool staffing after 3/31/17. We started hiring at that time and kept three of the float pool staff members. Our staffing over the last month has been a struggle and we have had to work short, especially with the NA staff. The struggle with filling staffing holes affected the residents by having them wait longer for call lights to be answered but I think the cares got done. I am the now the director of nursing (DON) and have not worked as a charge nurse but do supervise the second floor. I assign specific tasks to other staff members. On 3/27/17, I transferred to my role as DON. I know the daily schedule has me listed as the charge nurse but it is a name only thing. My job is only DON and I have never functioned as a charge nurse since being named DON.

On 4/13/17, at 12:17: p.m. the executive director stated the DON started on 3/25/17, and she has not worked as a nurse manager after that day. The Daily Staffing Schedules were wrong and the DON is in charge of the building but the ADON is the actual charge nurse of all 3 floors on the day shift. We do not have call light logs but we do audits on dining and call lights every weekend which we put into a summary. While auditing we also handle any staff or resident concerns or grievances that arise. We round throughout the facility, help serve a meal and monitor call lights. We stopped doing the audits on 3/6/17, but will be starting them back up next weekend. My

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2 800	Continued From page 39 expectation is a seven minute response time for call lights, and if this is not accomplished, we will do staff education and corrective action. On 4/3/17, at 12:22 p.m. the staffing coordinator stated the policy used for staffing was the previous owners policy. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could develop systems to ensure adequate staffing is in place for all nursing units to ensure resident needs are met. The director of nursing or designee could educate all appropriate staff on how to determine appropriate staffing levels and how to ensure adequate nursing staff is in place. The director of nursing or designee could develop monitoring systems to ensure nursing staffing needs are evaluated on a regular basis and that shiftly staff is monitored to ensure adequate to meet resident needs. The director of nursing or designee could bring monitoring results to the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830		5/25/17

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prefers to remain in bed.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide adequate pain management for 2 of 4 residents (R35, R73) reviewed with pain.

Corrected

Findings include:

R35 was observed continuously on 4/11/17, from 12:30 p.m. to 3:19 p.m. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes. NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F and NA-E assisted R35 to transfer to bed. When seated on the edge of the bed R35 stated. "God almighty! Help me! I'm leaning way over." NA-F lifted R35's legs into bed and R35 stated, "Ow."

On 4/11/17 at 3:45 p.m., licensed practical nurse (LPN)-C and LPN-B were observed to complete a right ankle dressing change for R35. LPN-C removed R35's right sock and reported there was a sore on her great right toe, not previously identified. LPN-C stated the ankle dressing being removed was dated 4/9/17 (two days prior). LPN-C reported no Allevyn was present on the ankle. R35 complained of pain when the dressing was removed. As LPN-C cleansed the wound with normal saline R35 screamed out, "That hurts!" LPN-B applied Santyl to entire wound bed and edges covered with Allevyn, wrapped with Kerlix, and dated the dressing.

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On 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. At 10:10 a.m. the surveyor informed the DON of serious concerns regarding R35's lack of timely services and pain management and she responded, "Me too." The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an assessment of the resident's skin condition. The DON changed the incontinent brief and provided peri-care. The DON then assessed the resident's skin condition and reported R35's left heel was lying directly onto the bed. R35 moaned in pain and stated she "hurts everywhere" when assisted to turn to her right side. R35 moaned, tightened her jaw and had furrowed brows when assisted to turn to her left side. The DON observed the left heel, which she stated was a suspected deep tissue injury measuring 1 cm x 1 cm x 1 cm. R35 reported the area was painful to touch. The DON put the gripper sock back onto the resident's left foot, which was directly on the mattress without a pressure reliving device in place. The DON confirmed she was aware of the status of R35's left heel last week, but did not know the severity of the wound and had not assessed it herself.

R35's annual Minimum Data Set (MDS) dated 2/7/17, indicated R35 had moderate cognitive impairment and had diagnoses including rheumatoid arthritis (known to contribute to pain), dementia and anxiety. In addition, the MDS indicated R35 required extensive assistance with activities of daily living (ADLs). Although pain was not identified on the annual MDS, R35 was noted to have a scheduled pain medication regimen. However, R35 had not been observed to be offered the as needed (PRN) medications or non-pharmacologic interventions for pain

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management prior to her dressing changes.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations due to pain. The CAA further identified R35 had chronic health issues/conditions, such as incontinence or pain that resulted in reduced activity participation.

R35's care plan dated 3/21/17, identified pain episodes due to rheumatoid arthritis, history of left knee pain, shoulder and generalized pain. R35's care plan directed facility staff to monitor/document/report to MD PRN any signs/symptoms of pain after exercise or weight bearing. The care plan further directed staff to anticipate need for pain relief, respond immediately to any complaint of pain, and to monitor/record pain characteristics. R35's care plan further directed staff to monitor for effectiveness of pain medication with follow through if ineffective, monitor/record/report to nurse any signs/symptoms of non-verbal pain, and "keep pain free and comfortable."

During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition. NA-F stated R35 requested to use the toilet at times, but was unable to bear weight, therefore, her incontinence brief was changed in bed. NA-F denied being aware of open areas on R35's buttocks, but had noticed red/yellow drainage from her right ankle on the bed sheet. NA-F stated R35 frequently complained of pain during the night.

On 4/12/17, at 9:14 a.m. trained medication aide

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(TMA)-D stated R35 yelled when staff was not responding to her requests for help. R35 received Tylenol for pain when she got up for the day, but usually not until 10:00 a.m. or 11:00 a.m.

NA-A stated on 4/13/17, at 8:17 a.m. R35 "always says she is in pain" and was "cussing when getting dressed and putting her in the wheelchair." R35 complained of pain in her feet and legs. NA-A stated they are supposed to check on R35 every 15-20 minutes. NA-A confirmed staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began.

On 4/13/17, at 11:05 a.m. NA-H stated she was aware R35 had wounds on her thighs, toe, ankle, and heel and that R35 had "a lot of pain" and would not let NA-H touch her right leg due to the pain. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch.

An interview was conducted with LPN-A via telephone on 4/13/17, at 11:12 a.m. LPN-A explained he had been the only nurse on the floor on 4/10/17, and "it was busy and difficult to get things done." LPN-A stated R35 was often "in pain and every part of her body is sore."

On 4/13/17, at 12:30 p.m. the DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but stated she felt it should be.

R35's progress notes from 3/6/17, to 4/11/17,

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identified on 3/6/17, R35's right inner malleolus was painful to touch and tender.

R35's physician orders included acetaminophen (Tylenol) 1000 milligrams (mg) by mouth twice daily for pain and once daily as needed (PRN).

Pain assessments dated 2/1/17 to 4/12/17, indicated an increase frequency and severity (1-10, with 10 being the most severe pain) of pain. In 2/17, R35 had pain two days rated at a 4 and 5. In 3/17, R35 had pain eight days rated at levels: 3, 6, and 8. Further, in March R35 required three doses of PRN acetaminophen. In 4/17, R35 had pain seven days rated at levels: 2, 4, and 5. Facility documentation for nursing assistants indicated R35 could be aggressive when in pain and exhibited agitation with pain.

The facility policy and procedure titled "Pain Management and Assessment" dated 7/28/15, indicated residents would receive the necessary comfort to perform activities of daily living.

R73 informed the surveyor on 4/11/17, at 1:24 p.m. he had been in pain for the last hour and requested his oxycodone-acetaminophen (combination opioid narcotic and non-opioid pain reliever for moderate to severe pain). R73 explained he was experiencing 8 out of 10 pain (10 being the worst possible pain) in his right shoulder and lower back. R73 reported when he had requested pain medication from the nurse, and he had been told he would have to wait because the keys to the narcotic box were missing.

R73's care plan dated 11/30/16, indicated R73 made his own decisions and had chronic pain in his right shoulder and back. R73's goal was to

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have pain controlled. Interventions included providing medication as ordered, monitoring causes of pain and notify nursing. R73's medication administration record (MAR) for 4/17, indicated he was to receive oxycodone-acetaminophen 5-325 milligrams (mg) 1 tablet every four hours for pain rated 1-6 or 2 tablets for pain rated 6-10. The last time R73 had been administered the medication was on 4/10/17, at 4:12 p.m.

On 4/11/17, at 1:30 p.m. RN-A explained he had misplaced the only set of keys that opened the narcotic box where R73's pain medication was kept. RN-A verified R73 had requested oxycodone-acetaminophen over an hour ago, but RN-A had still not found the keys and was still looking for them. The surveyor inquired as to what he planned to do regarding R73's pain management RN-A replied, "I know [R73] well enough that he can wait for his pain medication." RN-A stated he had informed the DON the keys were missing. At 1:37 p.m., after the keys were located, RN-A administered 2 tablets of oxycodone-acetaminophen to R73.

On 4/11/17, at 2:01 p.m. the executive director (ED) stated she would have expected the staff to care for residents' needs. "No resident should go in pain for over an hour and all residents should get their pain medication when they ask for it or provide another form of pain relief if appropriate." The ED was unsure if the facility had a second set of keys and would check with the maintenance director.

During an interview on 4/11/17, at 3:56 p.m. the DON explained RN-A asked whether she had picked up his medication cart keys by accident, because they were missing. The DON stated she

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2 830	Continued From page 46 was aware the keys were only missing a few minutes, as she had received a text a few minutes later that the keys had been located. The DON verified the facility did not have a back up set of keys to the narcotic box if the keys went missing. The DON said R73 should not have had to wait over an hour to get his pain medication. Instead, the RN should have called the pharmacist to obtain permission to take the needed medication from the Omnicell (medication storage system) or provided R73 with acetaminophen. In addition, the DON verified RN-A should have contacted her immediately when he noticed the keys were missing. The facility's 7/28/15, Pain Management and Assessment policy and procedure indicated residents would receive necessary comfort to perform activities of daily living. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure appropriate individualized pain management programs are in place. The DON or designee could educate all appropriate staff on the pain management systems. The DON or designee could develop monitoring systems to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and	2 840		5/25/17

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2 840	Continued From page 47 proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review the facility failed to ensure timely toileting services were provided for 1 of 1 residents reviewed (R35) who was completely dependent on staff for checking and changing.

Corrected

Findings include:

R35 was continuously observed on 4/10/17, from 1:58 p.m. to 4:15 p.m. At 1:58 p.m. R35 was seated in a wheelchair near the nurses' station with her head lowered in a chin to chest position and her eyes closed. The resident was wearing a Prevalon boot (soft blue boot used to aid in pressure relief) on her right foot. At 2:30 p.m. R35 remained in the same position; at 3:15 p.m. a nursing assistant (NA) walked by R35 but did not offer cares. At 3:50 p.m. R35 remained in the same position when the director of nursing (DON) walked past the resident. At 4:15 p.m. R35 remained in wheelchair without a change in positioning or assistance offered for at least 2 hours, 17 minutes.

The following day on 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to 3:19 p.m. R35 was seated in a wheelchair without being offered or assisted to reposition or toilet. At 12:30 p.m. while at the dining room table, her eyes were closed and she leaned to the right side. R35 was wearing the Prevalon boot on the right foot and a gripper sock on the left with both feet touching the floor. R35 remained in same position with no offers for cares or repositioning until 2:08 p.m. when R35

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2 840	Continued From page 49 called out, "Is anyone around? I'm ready to go to bed." No staff were present in the dining room. R35 then yelled, "Can I have some water?" Nurse consultant (NC)-F entered the dining room and provided R35 a glass of water and then left the room. At 2:22 p.m. NA-A asked R35 if she wanted to go sit by the nursing station which was declined. NA-A offered water and was declined. NA-A locked R35's right wheelchair brake and walked away. R35 yelled out "What time is it?" NA-A replied from the nursing station, "It's 2:25 in the afternoon." R35 again asked the time, and NA-A went to the resident to inform her of the time and ask if she wanted to sit by nurses' station. No cares were offered nor was the resident assisted with any cares. At 2:57 p.m. residents began gathering in the dining room for an activity. R35 remained at the table in the dining room with her head to her head to chest, eyes closed, and leaning to the right side. Life enrichment coordinator (LEC)-A moved R35's wheelchair slightly forward to accommodate another resident. At 3:01 p.m. licensed social worker (LSW)- B entered the dining room and left without offering assistance to R35. Housekeeper (HK)-A then asked R35, "You done eating?" R35 responded, "Yes." HK-A walked away to another table and left R35's food in front of her. At 3:06 p.m. R35's tray was removed, but no other cares were offered. At 3:19 p.m. NA-F assisted R35 out of the dining room and informed her she would help change her incontinence brief. R35 had not been assisted or offered to reposition/offload (remove pressure) for at least 2 hours, 49 minutes. NA-F, the DON and NA-E entered R35's room at 3:20 p.m. NA-F and NA-E assisted R35 to transfer to bed. When seated on the edge of the bed R35 stated. "God almighty! Help me! I'm	2 840		

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leaning way over." NA-F lifted R35's legs into bed and R35 state, "Ow." NA-F and NA-E removed the Prevalon boot, changed the incontinent brief and provided peri-care. NA-F described R35's brief as moderately wet. The DON then assessed the resident's skin condition. The DON stated R35's skin condition as: right upper buttock was open and excoriated from moisture, the left ischial tuberosity (hip) was boggy and non-blanchable. The left bottom buttock was reddened but blanched, right ischial tuberosity was blanchable, the right lower extremity had sores and scabs which had Tegaderm dressings, and the right medial ankle pressure ulcer and treatment was done at bedtime. R35's Prevalon boot was observed on the bed which the DON confirmed was soiled with blood and wound drainage. NA-F and NA-E changed R35's pants, as the ones she had been wearing were wet wet with urine. R35's wheelchair cushion was saturated with a circular area of urine and smelled strongly of urine. NA-F confirmed the cushion was wet with urine, and attempted to clean it with a Sani Wipe. NA-F reported she did not know the last time R35 had been changed or repositioned. R35 requested to get up again, and was assisted back into her wheelchair.

After the NAs and the DON left the room, licensed practical nurse (LPN)-C and LPN-B entered at 3:45 p.m. to complete a right ankle dressing change. LPN-C removed R35's right sock and reported there was a sore on her great right toe, not previously observed. The soiled dressing was Kerlix and gauze that was saturated with foul smelling yellow/blood-tinged drainage. LPN-C described the wound as "reddened with discoloration on the edges" and measured 5 centimeters (cm) x 4 cm x 1.5 cm.

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On 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. without being offered or assisted to reposition or use the toilet. At 7:03 a.m. R35 was resting in bed with her eyes closed, slightly tilted to her right side. The room had a strong urine odor. R35 continued in the same position until at 9:53 a.m. NC-F stopped at R35's door, looked in and continued to walk past the room. At 10:02 a.m. the surveyor attempted to locate an available staff person to intervene. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON was unaware why care had not provided care for R35. The DON stated R35 sometimes resisted care. The DON stated she felt staffing challenges contribute to timely care for R35. The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an assessment of the resident's skin condition. The DON changed the incontinent brief and provided peri-care. The DON described R35's brief as saturated with dark colored pungent smelling urine. The DON did not know the last time R35 was last changed or repositioned. The DON expected staff to follow the care plan and to change and reposition R35 at least every two hours.

R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 had moderate cognitive impairment and had diagnoses including rheumatoid arthritis (known to contribute to pain), dementia and anxiety. R35 required extensive assistance with activities of daily living (ADLs). R35 was not on a toileting program, however, was frequently incontinent of bladder and bowel.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations

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due to: weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. The CAA further identified R35 had chronic health issues/conditions, such as incontinence or pain that resulted in reduced activity participation. The CAA identified that R35 had urinary urgency and needed assistance in toileting which contributed to incontinence. The CAA also identified that R35 was offered toileting upon rising, after meals, at bedtime, and on rounds. R35 wore an incontinence brief to protect her skin and provide dignity.

R35's care plan dated 3/21/17, identified R35 needed assist of two staff members for toileting. R35 was to be checked at least every two hours for incontinence. The care plan directed staff to monitor for signs of incontinence decline and to offer/encourage the toilet upon rising, before and/or after meals, and at bedtime and during night rounds. Further, the care plan directed staff to assist with perineal hygiene after toileting, change incontinent briefs when soiled and to check brief for incontinence with rounding.

On 4/11/17, at 3:20 p.m. NA-F explained R35 did not like to lie down, however, she did not decline offers to have her incontinence brief changed or to reposition, as she was unable to move herself. NA-F stated R35 requested to use the toilet at times, but was unable to bear weight, therefore, her incontinence brief was changed in bed. NA-F denied being aware of open areas on R35's buttocks, but had noticed red/yellow drainage from her right ankle on the bed sheet. NA-F stated R35 frequently complained of pain during the night.

On 4/12/17, at 9:14 a.m. trained medication aide (TMA)-D said the reason R35 yelled was when

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staff was not responding to her requests for help. R35 received Tylenol for pain when she got up for the day, but not usually until 10:00 a.m. or 11:00 a.m.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A reported he had first seen R35 on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was Dr. was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. It was MD-A's impression the staff was elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff would implement pressure relieving interventions for R35's heels, ankle, and buttocks.

NA-A stated on 4/13/17, at 8:17 a.m. staff was supposed to check on R35 every 15-20 minutes. Staff were supposed to ensure R35's feet were off of the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.

On 4/13/17, at 10:56 a.m. NA-G stated she had repositioned and changed R35's wet incontinence brief at 7:00 a.m. NA-G stated the night shift had changed R35 at 5:00 a.m. NA-G reported R35 "screamed in pain" when assisted to reposition. R35 stayed in bed after incontinence care, and was reapproached at 10:00 a.m. and 10:35 a.m. to offer repositioning, but said R35 had refused.

However, on 4/13/17, at 11:05 a.m. NA-H reported she had changed R35's incontinence brief at 7:30 a.m. and the resident had been

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incontinent of both bowel and bladder. NA-H was unsure when R35 had been changed prior to that time. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's heels or feet.

On 4/13/17, at 12:30 p.m. the DON stated the "care plan is a mess and is not good" and the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. The DON expected staff to reposition, check and change R35 at least every two hours.

The care tracker was a tool for NAs to use to know R35's plan of care which indicated R35 was continent of bowel. The care tracker directed staff to monitor for urgency and give suitable time in the bathroom. R35 was frequently incontinent of bladder and to offer toileting with rounds. Staff was directed to offer/encourage to use toilet upon rising, before and/or after meals at bedtime and during night rounds.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) and/or designee could develop systems to ensure residents are assessed for and receive appropriate toileting assistance. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring plans to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assessment, monitoring and interventions were implemented in a timely manner for 1 of 1 resident (R35) reviewed with pressure ulcers. R35 suffered actual harm, deterioration of pressure ulcers and development of new pressure related breakdown. Findings include: R35 was observed continuously on 4/10/17, from 1:58 p.m. to 4:15 p.m. At 1:58 p.m. R35 was seated in a wheelchair near the nurses' station with her head lowered in a chin to chest position with her eyes closed. The resident was wearing a Prevalon (soft blue boot used to aid in pressure relief) on her right foot. The resident remained in	2 900	Corrected	5/25/17

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the same position throughout the observation. At 3:15 p.m., nursing assistant (NA)-A walked by the resident. At 3:50 p.m., the director of nursing (DON) walked by the resident. No staff were observed to offer repositioning or any other assistance throughout the 2 hour and 17 minute continuous observation.

On 4/11/17, continuous observations were conducted in the dining room from 12:30 p.m. to 3:19 p.m. R35 was seated in a wheelchair without being offered or assisted to reposition or toilet. At 12:30 p.m. approximately half of R35's meal remained, her eyes were closed and she leaned to the right side. R35 was wearing a Prevalon boot on the right foot, had a gripper sock on the left foot, and both feet were resting on the floor. R35 remained in the same position with no repositioning until 2:08 p.m. when R35 called out, "Is anyone around? I'm ready to go to bed." No staff were present in the dining room. R35 then yelled, "Can I have some water?" Nurse consultant (NC)-F entered the dining room and provided R35 a glass of water and left the room. At 2:22 p.m. NA-A asked R35 if she wanted to go sit by the nursing station, and R35 declined. NA-A also offered R35 a drink of water which the resident also declined. NA-A locked R35's right wheelchair brake and walked away. R35 yelled out "What time is it?" NA-A replied from the nursing station, "It's 2:25 in the afternoon." R35 again asked the time, and NA-A went to the resident to inform the resident of the time and asked her if she wanted to sit by the nurses' station. However no cares were offered. At 2:57 p.m. residents began gathering in the dining room for an activity. R35 remained at the table in the dining room with her head to her chin, eyes closed, and she was leaning to her right side. The facility's life enrichment coordinator (LEC)-A

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moved R35's wheelchair forward slightly to accommodate another resident. At 3:01 p.m. licensed social worker (LSW)- B entered the room and left without offering assistance to R35. Housekeeper (HK)-A then asked R35, "You done eating?" R35 responded, "Yes." HK-A walked away to another table and left R35's food in front of her. At 3:06 p.m. R35's tray was removed, but no other care was offered. At 3:19 p.m., 2 hours and 49 minutes after the continuous observation had started, NA-F assisted R35 out of the dining room and informed her she would help change her incontinence brief.

On 4/11/17 at 3:20 p.m., NA-F, the DON and NA-E, entered R35's room to help with her care. NA-F and NA-E assisted R35 to transfer to bed. When seated on the edge of the bed R35 stated, "God almighty! Help me! I'm leaning way over." NA-F lifted R35's legs into bed and R35 stated, "Ow." NA-F and NA-E removed the Prevalon boot, changed the incontinent brief and provided peri-care. NA-F described R35's brief as "moderately wet". However, when NA-F and NA-E changed R35's incontinent brief, they also changed her slacks because the slacks she'd been wearing were wet with urine. In addition, R35's wheelchair cushion was saturated with a circular area of urine and smelled strongly of urine. NA-F confirmed the cushion was wet with urine, and attempted to clean it with a Sani Wipe. The DON then assessed the resident's skin condition. The DON described R35's skin: right upper buttock- open and excoriated from moisture; left ischial tuberosity- boggy and non-blanchable; left lower buttock- reddened but blanches; right ischial tuberosity- blanchable; right lower extremity-sores and scabs which have Tegaderm dressings on them; right medial ankle- pressure ulcer with treatment scheduled for

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bedtime. R35's Prevalon boot was observed on the bed which the DON verified was soiled with blood and wound drainage. R35's wheelchair cushion was noted to be only about one half inch in thick and the DON stated, "it does not feel adequate." During the observation, NA-F reported she did not know the last time R35 had been changed or repositioned. After the care, R35 requested to get up again, and was assisted back into her wheelchair.

After the NAs and DON left the room, licensed practical nurse (LPN)-C and LPN-B entered at 3:45 p.m. to complete a right ankle dressing change. LPN-C and LPN-B performed hand hygiene and applied gloves. LPN-C removed R35's right sock and reported there was a sore on her great right toe, not previously observed. LPN-C stated the ankle dressing to be removed was dated 4/9/17 (two days prior). The soiled dressing was Kerlix and gauze that was saturated with foul smelling yellow/blood-tinged drainage. LPN-C reported no Allevyn was present on the ankle. R35 complained of pain when the dressing was removed. LPN-C described the wound as having "slough" (yellow fibrinous tissue that consists of fibrin, pus, and proteinaceous material) and said she could not visualize the wound bed. LPN-C stated the ulcer "was acquired because her ankles touch when she is in bed." LPN-C described the wound as "reddened with discoloration on the edges" and stated the wound measured 5 centimeters (cm) x 4 cm x 1.5 cm. LPN-B placed a barrier on the floor and placed supplies on the barrier. As she cleansed the wound with normal saline R35 screamed out, "That hurts!" LPN-B applied Santyl to the entire wound bed and edges, covered the wound with an Allevyn dressing, wrapped the entire area with Kerlix, and dated the dressing.

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2 900	Continued From page 59 On 4/12/17, continuous observations were conducted while R35 was lying in bed from 7:03 a.m. to 10:19 a.m. Throughout the observation, R35 was not offered any assistance with repositioning or toileting. At 7:03 a.m. R35 was resting in bed with her eyes closed, slightly tilted to her right side. The room had a strong urine odor. At 9:53 a.m. NA-F stopped at R35's door, looked in and continued to walk past the room. R35 remained in the same position until at 10:02 a.m. at which time the surveyor attempted to locate an available staff person to intervene. At 10:10 a.m. the surveyor informed the DON of the continuous observation of R35 without care. The DON stated she was unaware why care had not been provided for R35 but stated R35 sometimes resisted care. The DON stated she felt staffing challenges contribute to timely care for R35. The surveyor informed the DON of serious concerns regarding R35 and she responded, "Me too." The DON entered R35's room at 10:19 a.m. (3 hours, 16 minutes) and completed an assessment of the resident's skin condition. The DON changed R35's incontinence brief and provided peri-care. The DON described R35's brief as saturated with dark colored pungent smelling urine. The DON acknowledged she was unaware of the last time R35 had been changed or repositioned. The DON then assessed the resident's skin condition and reported R35's left heel was lying directly on the bed. R35 moaned in pain and stated she "hurt everywhere" when assisted to turn to her right side. The DON stated the left ischial tuberosity had superficial skin loss over the previously identified Stage I from 4/11/17. R35 moaned, tightened her jaw and had furrowed brows when assisted to turn to her left side. The DON then observed the left heel, and stated there was a suspected deep tissue injury measuring 1 cm x 1	2 900		

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cm x 1 cm. R35 reported the area was painful to touch. The DON put the gripper sock back onto the resident's left foot, which was directly on the mattress without a pressure relieving device in place. The DON confirmed she was aware of the status of R35's left heel last week, but did not know the severity of the wound and had not reassessed it. The DON confirmed a comprehensive assessment had not been completed or documented related to R35's excoriation on her buttocks, Stage I on left ischial tuberosity, and left heel deep tissue injury. The DON stated she would have expected these skin issues to have been assessed immediately upon discovery. In addition, the DON stated she expected staff to follow the resident's care plan and change and reposition R35 at least every two hours.

R35's record indicated the resident had multiple co-morbidities including: chronic kidney disease, signs/symptoms of peripheral vascular disease, dementia with behavioral disturbances, depression, and anxiety per her diagnosis list on the undated admission record, and consistent with a physician progress note provided by the facility following the recertification survey exit 4/14/17. Progress notes and medication/treatment administration records dated 1/6/17 through 4/13/17, indicated R35 had a history of intermittently refusing treatments and cares which included skin care treatment, assessments, physician appointments, and nutritional supplements.

A nutritional progress note dated 2/5/17, identified R35 had a low hemoglobin (8.7), low normal body mass index (19.3), and low normal body weight at 119 pounds. The nutritional progress note from 2/5/17, further noted R35's intake to be

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inconsistent, ranging from 26-100%. Nutritional goals were identified as: maintain stable weight, maintain hydration, and no skin breakdown. There was no further nutritional update.

R35's annual Minimum Data Set (MDS) dated 2/7/17, identified R35 had moderate cognitive impairment and had diagnoses including: rheumatoid arthritis (known to contribute to pain), dementia and anxiety. The MDS further indicated R35 required extensive assistance with activities of daily living (ADLs), had no pressure ulcers but was at risk. The MDS indicated a formal assessment tool and a clinical assessment were completed to determine R35's pressure ulcer risk.

R35's corresponding Care Area Assessment (CAA) dated 2/7/17, identified R35 needed physical assistance for ADLs and had limitations due to: weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. The CAA dated 2/15/17, identified R35 to be at risk for skin breakdown. There was no comprehensive assessment of R35's risk factors contributing to the potential for breakdown. The CAA for cognition dated 2/7/17, indicated problems with short and long term memory, resident had daily behavior of calling out for assistance and can "disrupt others, but is not danger or disrupt cares". Although the care plan printed 4/12/17, and provided by the facility as current identified a refusal of cares, there were no interventions identified to assist staff on what to do in the event R35 refused cares/treatments. Additionally, there were no specific interventions to minimize the risk for skin breakdown based on identified risk factors.

R35's care plan dated 3/21/17, indicated R35 had an actual alteration of skin integrity due to being

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cognitively impaired, assistance with ADLs, neurodermatitis, and had scratches/wounds on both lower extremities, left buttock, shoulder, and chest. R35's care plan directed facility staff to assist with repositioning frequently in bed in order to help R35 avoid laying on the open areas. The care plan directed staff to ensure that proper pressure reducing devices were in the wheelchair, and that R35 was positioned correctly when transferring to wheelchair. Further, the care plan directed staff to "assist with repositioning in bed to avoid laying on open areas frequently". The care plan did not address R35's suspected deep tissue to left heel, unstageable ulcer to right heel, right inner ankle press ulcer, or right great toe wound. The care plan did not include interventions defining how often R35 needed to be turned/repositioned, nor did the care plan include other pressure reducing/relieving interventions.

During an interview with NA-F on 4/11/17, at 3:20 p.m. she explained R35 did not like to lie down however, NA-F stated R35 did not decline offers to have her incontinence brief changed or offers to assist her reposition. NA-F verified R35 was unable to move herself. NA-F also stated that although R35 requested to use the toilet at times, she was unable to bear weight therefore, she required assistance to change her incontinence brief. NA-F stated if she observed a new skin alteration, she would inform the nurse at that time. NA-F denied being aware of open areas on R35's buttocks, but stated she had noticed red/yellow drainage from her right ankle on the bed sheet. NA-F stated R35 frequently complained of pain during the night.

On 4/12/17, at 9:14 a.m. trained medication aide (TMA)-D said R35 yelled when staff did not

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respond to her requests for help. TMA-D also stated R35 received Tylenol for pain when she got up for the day, but not usually until 10:00 a.m. or 11:00 a.m.

On 4/12/17, at 1:44 p.m. nurse practitioner (NP)-A stated she was new to the facility and unfamiliar with R35. NP-A stated it was an expectation the staff would contact the NP regarding any new skin alterations, but verified she had not been informed of any problems with R35's skin since she'd begun seeing the resident on 4/3/17. NP-A said if skin alterations were observed, NP-A would institute orders to off load pressure and would implement pressure relieving interventions. If a new wound had developed, she would potentially order a Mepilex dressing.

A telephone interview was attempted with the medical director and a voicemail message was left on 4/12/17, at 2:19 p.m.

On 4/12/17, at 6:15 p.m. a telephone interview was conducted with the wound physician (MD)-A. He reported he saw R35 for the first time on 4/7/17 and was following the right medial ankle and right heel pressure ulcers. MD-A was unaware of the left suspected deep tissue injury and skin break down on R35's buttocks. MD-A expected to be notified of significant decline in wounds. It was also expected daily dressing changes would be performed on R35's right ankle. MD-A reported R35 had a Stage IV ankle ulcer, and would have increased in size/severity without appropriate dressing changes. It was MD-A's impression the staff were elevating R35's heels, and at a minimum would have expected the heels to be off the bed, and the resident would be repositioned out of her wheelchair at least every two hours. It was also expected staff

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would implement pressure relieving interventions for R35's heels, ankle, and buttocks.

NA-A stated on 4/13/17, at 8:17 a.m. R35 "always says she is in pain" and was "cussing when getting dressed and putting her in the wheelchair." R35 complained of pain in her feet and legs. NA-A stated they are supposed to check on R35 every 15-20 minutes. Staff was supposed to ensure R35's feet were off the bed and she had a boot on, but NA-A was unsure which foot or when this intervention began. NA-A was unaware if there had been changes to R35's care plan.

On 4/13/17, at 8:28 a.m. LPN-D reported she was aware R35 had sores on her legs and hip. R35 slept from 10:00 a.m. to 1:00 p.m. but it was still expected the NAs would check on the resident because of her skin issues. LPN-D believed the right hip area was due to pressure, and the other wounds were from scratching and picking at herself. LPN-D was unfamiliar with other wounds, as they had not been passed on during shift to shift reporting.

On 4/13/17, at 10:56 a.m. NA-G stated she had repositioned and changed R35's wet incontinence brief at 7:00 a.m. NA-G stated the night shift had changed R35 at 5:00 a.m. NA-G reported R35 "screamed in pain" when assisted to reposition. R35 stayed in bed after incontinence care, and was reapproached at 10:00 a.m. and 10:35 a.m. to offer repositioning, but said R35 had refused. NA-G was unsure if R35 had wounds on her feet, or whether any changes had been made to her care plan in the last week.

However, on 4/13/17, at 11:05 a.m. NA-H reported she had changed R35's incontinence

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brief at 7:30 a.m. and the resident had been incontinent of both bowel and bladder. NA-H was unsure when R35 had been changed prior to that time. NA-H was aware R35 had wounds on her thighs, toe, ankle, and heel. R35 had "a lot of pain" and would not let NA-H touch her right leg due to the pain. NA-H stated R35 was on a repositioning program of every two hours in bed, but did not have a wheelchair repositioning program. NA-H stated when R35 was in bed, she needed a pillow between her legs so her ankles did not touch. NA-H did not place a pillow under the resident's heels or feet.

An interview was conducted with LPN-A via telephone on 4/13/17, at 11:12 a.m. LPN-A stated he worked on 4/10/17, but did not recall completing a dressing change that day. LPN-A stated when dressing changes were performed he usually dated and initialed the dressing, but at times was "busy and rushed" so may not have done so. LPN-A explained he had been the only nurse on the floor on 4/10/17, and "it was busy and difficult to get things done." LPN-A stated R35 was "in pain and every part of her body is sore." LPN-A was unaware of any other skin issues other than a pressure sore on the right ankle.

On 4/13/17, at 12:30 p.m. the DON identified the following pressure related skin issues at the time of the survey: suspected deep tissue to left and right heel, right inner ankle, and right great toe wound. The DON stated R35's right ankle wound was first observed on 3/2/17 and though it had been monitored weekly the record lacked evidence of monitoring. The DON was aware of R35's left heel ulcer on 4/12/17, but it was not reflected in the documentation. The DON stated that the "care plan is a mess and is not good" and

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2 900	Continued From page 66 the DON was in the process of updating it. The DON confirmed there were no pressure relieving interventions noted on the care plan. Prior to the survey entrance the DON said she had not thought of putting a different mattress on R35's bed. The DON expected staff to reposition, check and change R35 at least every two hours. The DON expected nurses to monitor R35's skin every shift and assess once weekly on bath day, and to document findings. In addition, it was expected a comprehensive skin assessment would be completed when a new area was found. This included a head to toe assessment of skin, documentation of the location of wounds, wound measurements, with completion of a risk management form. The DON stated the current order for R35's right ankle was to apply Santyl, calcium alginate, cover with Allevyn and wrap with Kerlix. The expectation was for nurses to read the orders prior to completing the dressing change. The DON stated the right and left heel were to have skin prep applied, but verified this intervention was not identified on the Treatment Administration Record (TAR) or Medication Administration Record (MAR). The DON did not have any current in-service material showing staff had been provided education on wound training. The DON expected the nurse to immediately notify the NP when the skin alteration was observed, and the NP ultimately oversaw care for R35. The DON stated R35 experienced pain with dressing changes. She was unsure whether pre-medication for pain was provided for R35 prior to care and dressing changes, but the DON stated she felt it should have been. Review of R35's progress notes from 3/6/17, to 4/11/17, identified on 3/6/17, R35's right inner malleolus was painful to touch and tender and there was no notation regarding an update to	2 900		

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2 900	Continued From page 67 physician. On 4/1/17, a skin check was completed with documentation of: "Other right heel-pressure stage unstagable, right ankle (inner) pressure- stage II" and identified no new skin areas. The following day on 4/2/17, documentation identified that the dressing charge to right ankle was completed and had a large amount of yellowish drainage from the wound site. Documentation lacked evidence that the provider had been notified. On 4/6/17, the progress note identified the right ankle dressing change was completed and the wound looked bigger, had a white substance in the wound site and was odorous, however, the record lacked documentation that the physician had been updated. Review of R35's weekly wound documentation from 3/2/17, to 3/31/17. 3/2/17, right inner ankle was identified on this date by nurse manager with measurements of 2.0 x 2.5 cm and classified as an unstagable. Documentation identified that area was debrided on this date, depth is superficial, has 100% slough, a moderate amount of serous drainage, and pain associated with wound. Weekly wound documentation on 3/9/17, 3/16/17, 3/23/17, and 3/31/17, all indicated right inner ankle measurements of 2.0 x 2.0 x cm and classified as a stage IV. Documentation identified the depth was superficial with 100% slough and moderate serous drainage, and pain associated with wound. Documentation had a radio button marked that indicated MD/Physician/NP/Medical Professional and family were notified. However, nursing weekly wound documentation and R35's record did not reflect the right medial heel.	2 900		

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Review of R35's weekly wound care specialist evaluation documentation from 3/2/17 to 4/7/17 revealed::

1) 3/2/17: unstageable (due to necrosis or dead tissue) of the right, medial ankle of at least 5 days duration with measurements of 2 cm x 2.5 cm x not measurable depth cm with light serous exudate and 100% thick adherent devitalized necrotic tissue. The wound was cleansed and using surgical technique was devitalized tissue and necrotic SQ (subcutaneous) fat was removed at a depth of 0.1 cm . There is no indication of pain associated with this condition.

3) 3/9/17: unstageable right medial ankle with measurements of 2 cm x 2 cm x not measurable depth with moderate serous exudate and 90% thick adherent devitalized necrotic tissue with 10% granulation tissue. Documentation identified no change in wound progress. The wound was cleansed and with surgical technique devitalized tissue and necrotic muscle and surround fascial fibers were removed. There is no indication of pain associated with condition.

4) 3/16/17: unstagable right, medial ankle pressure wound which had light serous exudate. Documentation identified that R35 appeared to have associated pain evidenced by agitation. Measurements were 3 cm x 3 cm x not measurable with 100% granulation tissue and wound progress deteriorated. R35 appeared to have associated pain evidenced by agitation.

5) 3/31/17: unstageable (due to necrosis) of the right, medial heel, of at least 1 day in duration. There is no exudate with measurements of 1.5 cm x 1.3 cm x not measurable. Documentation identified 100% thick adherent black necrotic

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tissue. Skin prep was ordered daily. Right medial ankle was documented of measurements of 4.0 cm x 3.5 cm x 0.2 cm with light sero-sanguinous exudate, 85% granulation tissue, 15% other tissue, and tendon visible. No indication of pain associated with condition.

6) 4/7/17: right medial heel with measurements of 2.0 cm x 2.0 cm x not measurable with 100% thick adherent black necrotic tissue and no change in wound progress. R35's right medial ankle was measured at 4.0 cm x 4.0 cm x .02 cm with maceration at periwound radius, moderate sero-sanguinous exudate, 15% other tissue, 85% granulation tissue and tendon observed. Documentation identified there was no change in wound progress, nor was there an indication of pain associated with condition.

The facility's undated Repositioning and Turning policy and procedure indicated: "Residents are turned/positioned in accordance with the plan of care to prevent skin breakdown. Residents who are unable to reposition themselves will be turned and repositioned every one to two hours in accordance with their needs, using a written care plan as determined by licensed staff. The Charge Nurse is responsible for incorporating the plan, approaches, and goal on the care plan."

A 4/21/14, facility specific Wound Care Program document indicated a Braden Scale was to be completed upon resident's admission and weekly for the first 4 weeks of admission to determine the score and the level of risk for skin breakdown. Then, the risk factor(s), potential cause(s) and interventions should be reviewed and addressed on the care plan. The document further indicated that when a resident is in bed or wheelchair they should be turned/reposition at least every two

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2 900	Continued From page 70 hours or as indicated on the resident's care plan. The care plan shall be evaluated and revised based on the resident's response to treatment, goals, and outcomes. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure adequate treatment/prevention of pressure ulcers, including but not limited to timely, comprehensive assessments and care plan development/revisions. The DON or designee could educate all appropriate staff on the systems. The DON or designee could develop monitoring systems to ensure ongoing compliance and review those results with the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure sanitary food was served to 3 of	21000	Corrected	5/25/17

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13 residents (R20, R55, R17) served a meal in the 3N dining room. This had the potential to affect 9 additional residents in the 3N dining room.

Findings include:

3N Meal Service
On 4/10/17, at 5:31 p.m. 13 residents were observed sitting at tables in the 3N dining room. At 5:40 p.m. another resident walked in and sat down.

At 5:41 p.m. the cook was observed standing behind the steam table touching the residents' meal tickets with gloves on. The cook then picked up a bun, broke it in half and placed it on a plate, meat was picked up with her gloved hand, placed on the plate, and taken out to the dining room. The cook pulled foil off the pans of food on the steam table, walked over to the garbage can and with both gloved hands pushed down the cover of the dirty garbage can cover.

At 5:45 p.m. while holding a plate in the same gloved left hand, the cook scooped ground rice and mashed potatoes for R20. The cook placed her same gloved left hand on the yellow wet sign behind her and with the gloved right hand touched her clothing and pulled up her slacks. The cook picked up a plate with the gloved left hand and picked up a bun with the gloved right hand, used tongs to place a hamburger on the plate. With the gloved left hand turned the hamburger around on the plate for R55 and touched the bun for R17 with the same gloved hands. The cook was going to have nursing assistants take the plates out to the residents when the surveyor intervened. The Dietary Director (DD) was informed of observation with

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the gloves touching the dirty garbage can cover touching residents' food with the same dirty gloved hands. DD instructed the cook to take off her gloves and put new gloves on and instructed cook to throw the three plates of food away. DD also stated the cook should not be touching the individual residents' meal tickets as staff and residents touched them. Cook stated she had been a cook for almost one month and a half, was trained to wear gloves and would take the gloves off after going downstairs to the kitchen.

Policy provided by the facility Bare Hand Contact with Food and Use of Plastic Gloves dated 2010, indicated "Plastic gloves will be worn when handling food directly with hands to ensure that bacteria are not transferred from the food handlers' hands to the food product being served. Bare hand contact with food is prohibited. Gloved hands are considered a food contact surface that can get contaminated or soiled. Anytime a contaminated surface is touched, the gloves must be changed."

SUGGESTED METHOD OF CORRECTION: The director of nutritional services or designee could develop systems to ensure proper hand hygiene for food handlers. The director of nutritional services could educate all appropriate staff on hand hygiene. The director of nutritional services or designee could develop a montiring system to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21015	Continued From page 73	21015		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure refrigerators were sanitary in kitchenettes on 3 of 3 units observed. Findings include: On 4/10/17, at 12:34 p.m. during a tour of dietary services with the DD, it was noted each floor had a refrigerator. The third floor refrigerator contained a bowl of oatmeal, not dated or sealed. There is a darker colored liquid spilled in the drawers and there were butter packs and milk creamer containers sitting in this liquid in the drawers. In the second floor refrigerator, there were two sealed containers of spaghetti on the shelf not dated or labeled. In the first floor refrigerator, the freezer had what looked like cherry pie on a plate not covered, sealed or dated. All three refrigerators had spilled food and were not clean. The DD stated that maintenance was responsible for the cleaning of these units. On 4/11/17, at 8:24 a.m. the maintenance director (MD) stated he was not aware that his department was responsible for this and he would "check into it." He stated he had been the maintenance supervisor for approximately one month, so he didn't know who was responsible, but would find out.	21015	Corrected	5/25/17

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21015	Continued From page 74 On 4/11/17, at 9:15 a.m. the DD stated the refrigerators were the housekeeping responsibility and they had been cleaned. The MD stated he did obtain a cleaning schedule and it was provided to the surveyor SUGGESTED METHOD OF CORRECTION: The director of dietary or designee could review and/or revise policies and procedures for ensuring sanitation of the kitchen on the nursing units. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to prevent and control the spread of infection related to the cleansing of the blood glucose monitoring machines. This had the potential to affect 5 of 5 residents on the second floor who shared the same glucometer.	21375	Corrected	5/25/17

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Findings include:

On 4/10/17, at 6:35 p.m., licensed practical nurse (LPN)-A performed a glucometer check on R70. After leaving the room, LPN-A cleansed the glucometer with an alcohol wipe. At 7:21 p.m. LPN-A confirmed he cleaned the glucometer with an alcohol wipe. LPN-A stated he should have used saniwipes to clean the glucometer but the facility was out of saniwipes. LPN-A identified the glucometer is used on multiple residents.

On 4/12/1, at 7 8:05 a.m. (RN)-D wiped off glucometer after using on resident with Saniwipe, then got a new Saniwipe and left glucometer wrapped in wipe for at least two minutes.

On 4/13/17, at 9:40 a.m. registered nurse RN-C stated 5 residents currently used the glucometer that was cleansed with alcohol wipes. RN-C stated proper cleansing of glucometers is to wipe off glucometer with saniwipe and then wrap glucometer in saniwipe for two minutes.

The director of nursing (DON) stated on 4/12/17, at 3:18 p.m. that staff was expected to clean the glucometer with one saniwipe and then wrap the glucometer in another saniwipe for 2 minutes. The DON stated there were saniwipes available in the building on 4/10/17.

The facility's undated policy "Maintaining the Blood Glucose Meters" identified to clean and disinfect the meter, use pre-moistened wipe/towel of 1 ml or 5-6% sodium hypochlorite solution (household bleach) and 9 ml water to achieve a 1:10 dilution final concentration of 0.5-0.6% sodium hypochlorite.

SUGGESTED METHOD OF CORRECTION:

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21375	Continued From page 76 The director of nursing (DON) or designee could review and revise policies and procedures pertaining to glucometer sanitization. The DON or designee could educate all appropriate staff on these systems. The DON or designee could develop monitoring systems to ensure ongoing compliance and review those results with the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced	21426		5/25/17

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EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 77 by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) risk assessments were completed for 2 of 5 employees (E-A, E-B) and tuberculin skin testing (TST) administered as required for 2 of 5 employees (E-C and E-D) whose employee files were reviewed. In addition, the facility failed to ensure TB risk assessments were completed for 4 of 5 residents (R110, R89, R74, R109) and TST administered timely for 1 of 5 residents (R109) whose immunization records were reviewed. Findings include: Employees: 1) E-B was hired 3/9/17, however, the employee's file lacked evidence of TB symptom screening and TST administration. 2) E-C was hired 3/27/17. The employee's file revealed the first TST was administered on 3/22/17, however, there was no evidence a second test had been administered as required. 3) E-A was hire 10/5/15, and the employee's file lacked evidence a TB symptom screening was completed annually. Residents: 1) R110 was admitted 3/14/17. R110 immunization records lacked evidence an assessment for risk factors and screening for active symptoms of TB had been completed. 2) R89 was admitted 12/13/16. R89's immunization record lacked evidence an assessment for risk factors and screening for active symptoms of TB had been completed. 3) R74 was admitted 2/16/17. R74's immunization record lacked evidence an assessment for risk factors and screening for active symptoms of TB had been completed.	21426	Corrected	

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21426	Continued From page 78	21426		

4) R109 was admitted 3/23/17. R109's immunization record lacked evidence an assessment for risk factors and screening for active symptoms of TB had been completed. In addition, TST was administered 15 days post-admission.

On 4/13/17, at 12:24 p.m. health unit coordinator (HUC)-D verified no other documentation was available related to employee and resident immunization records.

On 4/13/17, at 1:30 p.m. the DON provided the facility's infection control plan, which indicated the facility was at medium risk. The DON stated was that all employees received symptom screening for TB upon hire and annually thereafter. At hire employees were to have the two-step TST completed; with the second step being administered three weeks after first. The DON also stated residents were screened at admission and annually thereafter. Upon admission residents were administered the two-step TST and then one-step annually. The DON confirmed the employees and residents had not been screened as required.

The facility's 8/1/15, Tuberculosis Surveillance and Control policy identified "All residents new to long term care who do not have documentation of a previous skin test...shall have initial test of Mantoux PPD [purified protein derivative] two-step skin test to rule out tuberculosis (TB) within one month prior to or one week after admission as required...second test should be given at least one week and no more than three weeks after the first test. Staff must be vigilant for signs and symptoms of TB in residents who are to be evaluated, at least, annually to assure absence of signs and symptoms for TB disease."

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21426	Continued From page 79 Additionally, the policy indicated "occupationally-exposed persons should be tested at least annually...provide a tuberculin skin test to all employees during pre-employment procedures and if results are 0-9 mm [millimeters], a second test should be given at least one week and no more than three weeks after first test...employees will be skin tested on an annual basis as a means of surveillance within a facility." SUGGESTED METHOD FOR CORRECTION: The director of nursing and infection control nurse could review policies and procedures. Training could be provided as appropriate. An auditing system could be implemented, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who self-administered medications were assessed as capable to do so for 1 of 1 (R53) resident who self-administering medication.	21565	Corrected	5/25/17

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21565	Continued From page 80	21565		

Findings include:

R53 was interviewed on 4/10/17, at 5:08 p.m. when licensed practical nurse (LPN)- A brought in R53's evening medications. The medications included an Ipratropium-Albuterol nebulizer treatment. LPN-A looked at the nebulizer mask and reported there was still medication left in the mask. Without re-starting the treatment and ensuring R53 received all of the medicine, LPN-A left the room. LPN-A then documented that the Ipratropium-Albuterol nebulizer was given on R53's medication administration record (MAR).

On 4/10/17, at 7:21 p.m. LPN-A stated that he should have set up the nebulizer treatment for R53 but did not because the resident still had medication left in his nebulizer mask.

R53's physician orders included Ipratropium-Albuterol Solution 0.5-2.5(3) milligrams/3 milliliters, 1 vial inhale orally four times a day for chronic obstructive pulmonary disease. R53's record also lacked evidence the resident had been assessed for self-administration of medications, and R53's current care plan did not reflect the resident was capable and chose to self-administer the nebulizer treatment.

The director of nursing (DON) stated on 4/12/17, at 2:30 p.m. R53 was able to self-administer medications. However, at 3:18 p.m. the DON verified the staff had not completed an assessment that showed R53 was capable of self-administering the nebulizer treatment.

4/13/17, at 11:01 a.m. the DON verified LPN-A should have ensured the nebulizer treatment was completed, or documented R53 did not receive

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21565	Continued From page 81 the medication. The facility's undated Self-Administration Medication Policy and Procedure directed "A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate." SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee could develop systems to ensure regulatory compliance and resident safety during self administration opportunities. The DON or desginee could educate all appropriate staff on these systems. The DON or designee could develop monitoring to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21565		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication carts were locked to minimize the risk of drug diversion for 1 of 7 carts. Finding include:	21610	Corrected	5/25/17

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21610	Continued From page 82	21610		

On 4/12/17, at 7:41 a.m. 3 North's medication cart was observed in the hallway unlocked and no staff was observed on the unit. R27 walked by the unlocked medication cart and continued toward the dining room area. A maintenance staff and the unit nursing assistants walked by the cart and proceeded with their normal routine. At 7:51 a.m. registered nurse (RN)-C was observed coming out of R60's room and walked over to the unlocked medication cart. RN-C verified she was the nurse working on the medication cart and immediately stated she forgot to lock the cart when she went into R60's room. RN-C explained the facility policy and procedure is to lock the cart every time you leave it. RN-C verified while the cart was unlocked residents and staff could take medications.

On 4/13/17, at 8:47 a.m. the director of nursing stated her expectation regarding medication carts was they were to be locked at all times when staff was not present.

On 4/13/17, at approximately 9:30 a.m. R43 was observed wandering around 3 North. When R43 reached the medication cart she attempted to pull on the drawers which were locked. She then she reached into the trash on the side of the cart, pulled out a plastic cup, looked at it placed it back in the trash.

The facility's policy and procedure titled "Medication Storage" dated 8/1/15, indicated compartments containing medication should be locked when not it use.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and

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21610	Continued From page 83 procedures to ensure medications are stored appropriately. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance and share those results with the QA/QI committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide a functional and comfortable environment. This affected one resident R5 with comfortable temperatures and had the potential to affect all 69 residents residing in the facility. Findings include: On 4/12/17, at 2:00 p.m. the maintenance director (MD) stated he became the director a month ago and there was another maintenance staff who worked full time. MD stated staff notified him of work requests either on his cell phone or with TELS orders on the computer.	21685	Corrected	5/25/17

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21685	Continued From page 84 During the environmental tour on 4/12/17, at 2:00 p.m. verified a small circular gouge on the room door in room 202 he had not been aware of. MD took temperature of room 221 and laser gun read 68 degrees by the window and 70.5 degrees by the bed. MD stated, "I think I know why it is cold in this room" and went over to the window and closed window tight. MD stated the window had not been completely closed and that he knew why. MD stated staff had come to him last week on one of the 70 degrees days and wanted to be able to open that window. MD stated it took a tool to open the window. MD stated now with the window completely closed up tight the room should now hold its heat. MD stated he did not think staff were aware of how to close the window tight and how that affected the temperature in the room. The following morning on 4/13/17, at 10:26 a.m. in room 221, MD verified the temperature with a laser gun was 66 degrees under the window and 72 degrees by the bed. MD stated the boilers were turned on for the night and off for the day. MD stated closing the window had eliminated the draft coming into the room. MD stated it still felt chilly in the room and took temperature of the window on the opposite of the room and it read 59 degrees, 62 degrees and 64 degrees on each individual pane. A draft was felt on the right side of the window. MD verified what looked like old sticky tape on the window. MD stated looks like there once was a draft block tape felt and could redo it to help keep the draft out of the room. MD stated he did not know what temperature range the facility should be but stated it should be what the residents wanted. MD stated he would fix the window in the room and that should help warm up	21685		

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21685	Continued From page 85	21685		

the room. R5 was wheeling self down the hall to her room 221 and stated to MD that her room was still cold this morning. MD told R5 about her roommate's window being drafty. R5 stated she hated feeling cold and had wondered if that window had been drafty but had not mentioned that to staff or to MD the last time he had helped with her window in the room. MD stated he would put a covering on her roommate's window to cut down the draft. (R5 had complained of being cold in her room on 4/12/17, at 9:50 a.m. to another surveyor for the last few months and that staff was aware. R5 also stated that NAs would come in her room and try to heat up the room by turning up the thermostat but R5 would tell the NAs no, as it just blew cold air.)

On 4/12/17, at 2:00 p.m. in room 311, MD verified the bottom drawer of the closet was missing leaving a metal bracket exposed. MD also verified a large gouge on the bottom of the closet door he had not been aware of. MD verified cracked baseboard tile along the bathroom floor wall in bathroom and large cracked splitting ceiling tile almost in half holding the vent which MD stated he had not been aware of. MD stated it looked like a mop handle had hit it.

In room 319 MD verified the room door and the bathroom door were scratched up through the middle and a large portion of the wall between the residents had missing paint. MD stated he had not been aware of the room needing paint but had been aware of the scratched doors. MD stated he thought the door handle was scratching the other door.
On the 3N unit, MD verified cabinets were sitting in cardboard boxes by a plastered wall. MD stated the plan was to put new cabinets, counter and sink in. MD stated the old cabinets and sink

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21685	Continued From page 86 had been taken out four weeks ago and that he was hoping to get the new counter put in next week. MD stated the old cabinets and sink had been removed to update the dining room and make it look nicer. MD stated it had unfinished for about a month and hoped he could find time to at least get back to it next week. In room 307, MD verified a missing closet door and the soap dispenser did not work. Small trickles of soap would come out of dispenser with continuous pressure put to it. MD stated he had known about the soap dispenser not working and thought it may needed new batteries which he had not replaced yet. MD stated the closet door had been off for over a month and they had not been able to get to it. MD stated the frame needed more wood before the new door could be put on as it would leave a gap. During the tour, Family Member (FM)-B came out of room 307 and told MD the television in the room did not work. FM-B told MD the television had stopped working over the weekend and she told staff. MD stated he had not been informed by staff and that he would get a new television put in this afternoon. MD verified the television did not work and needed replacing. MD stated it was a facility television therefore the facility needed to replace it. On the 3S unit, by the elevator MD verified missing wallpaper approximately half a foot and also wallpaper few inches ripped in the hall to the right of room 319. MD stated he had not heard of any plans for the 3S unit. MD stated they were trying to triage the work and look residents' rooms over when residents discharged. MD stated they had been busy updating the facility and trying to do things as they were noticed. MD stated they were called off to do other things and had to prioritize the work. MD stated he had a list of things to get done. MD	21685		

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21685	Continued From page 87 stated he had no work requests for any of the things looked at on the tour. On 4/13/17, at 10:26 a.m. on first floor MD verified plaster on the walls between rooms 109 and 108 plastered holes and a gouged hole in the plaster across from room 107, and scratched walls in the hall by room 100. MD stated hall walls needed continual touch-up. In room 221, MD verified four holes with blue putty sticking out above the sanitizer dispenser on the wall and stated it had always been that way and it did not look nice. In room 223, MD verified holes in the closet door, stating he could use stain putty to repair. MD added last week he had to fill in for every department under him (laundry, housekeeping, janitorial, maintenance) as staff had been absent. In 3N unit, MD verified white chipped marks on the wall across from the elevator stating they needed touch-up and that walls were a constant touch up due to residents' wheelchairs. On 4/13/17, at 12:11 p.m. MD verified plastered spots in halls on first floor at the entrance door and at back stairway door. MD stated wall touch ups was needed ongoing from wheelchairs, and that he would need to touch up. MD stated the facility no longer had a Preventative Maintenance plan, had had one at one time but had been busy with remodeling. MD stated with new ownership would now be two maintenance instead of the three fulltime maintenance the facility had. MD stated the previous director had recently left employment and would now just keep two maintenance, was a new ownership decision. MD stated he would need to put a plan in place for Preventative Maintenance. MD stated he did not have any work order requests for the environmental issues verified. MD stated he was not aware of any environmental/maintenance policies for the facility.	21685		

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21685	Continued From page 88 SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and implement policies and procedures and educate appropriate staff to ensure that the residents's environment was maintained in a safe, clean, functional, comfortable manner. The administrator or designee could educate all appropriate staff on the systems in place to ensure the environmental issues are identified and appropriately addressed. The administrator or designee could develop auditing systems to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal cares in a manner which promoted privacy and dignity for 2 of 4 residents (R1, R49) observed for activities of daily living (ADL's), and to provide a dignified dining experience for 1 of 13 residents (R49) served in the 3 north (3N) dining room.	21805	Corrected	5/25/17

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21805	Continued From page 89	21805		

Continued From page 89

Findings include:

R1 was observed receiving morning cares on 4/12/17, at 7:18 a.m. by nursing assistant (NA)-L. R1 was lying in the bed closest to the door. The room had two large windows, one of which faced an adjacent apartment complex. NA-L provided peri care to R1 without shutting the window shades or pulling R1's privacy curtain. NA-L removed R1's gown walked across the room to retrieve clothing items for R1 leaving her upper and lower private areas exposed to anyone who may have entered the room or potentially view from the outside.

R1's care plan dated 3/9/17, revealed she dementia, severely impaired decision making abilities with short and long term memory loss, and required extensive assistance to dress. The staff was directed to anticipate and meet the resident's needs and to decrease episodes of agitation.

NA-L reported on 4/12/17, at 7:35 a.m. she had been a NA for several years. When asked about providing privacy during cares NA-L replied, "Oh sorry," then pulled the privacy curtain shut. NA-L explained the facility's policy and procedure was to provide dignity by pulling the shades and privacy curtain, and ensuring the door was closed. NA-L verified she should have provided privacy for R1 to ensure she was not exposed.

R1 was interviewed following the observation and how she felt about not being covered during cares. R1 replied, "It doesn't bother me. This is how they do it everyday. What can I do?"

During an interview on 4/12/17, at 1:46 p.m. the executive director (ED) stated he expected staff

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EDINA CARE & REHAB CENTER	6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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to provide dignity and privacy to all residents by pulling the curtain and closing the door.

The facility's 1/12, Policy on Resident Rights, Respect & Dignity policy and procedure noted "staff are responsible to maintain and enhance residents self-esteem and worth, by providing personal privacy."

R49 was observed on 4/11/17, at 8:34 a.m. while seated at a table in the 3N dining room. R49 was served a plate of food with a pancake, a sausage patty and scrambled eggs. R49 ate bites of her scrambled eggs with a spoon, but ate the uncut pancake and uncut sausage patty with her fingers.

At 8:45 a.m. NA-P sat down at R49's table and helped another resident to eat. No assistance was provided by NA-P or other staff in the room to cut R49's food or encourage her to utilize utensils.

The following morning on 4/12/17, at 8:25 a.m. R49 was observed sitting at the table in the dining room. NA-K set a plate of food in front of R49, and asked if she wanted her french toast and sausage cut, but did not offer to also cut her bacon. R49 replied "yes." The french toast was cut and added maple syrup. NA-K quickly made a couple of cuts into R49's sausage patty and then walked away. Although the patty had cut marks on it, it was not fully cut through or into bite-sized pieces. R49 picked up her fork and stabbed at the patty, and then picked it up with her fingers and pulled off a piece. She picked up a piece of bacon and broke it into pieces.

At 8:34 a.m. NA-P sat down by R49's tablemate. R49 unsuccessfully attempted to cut up her

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sausage patty up with a fork, and eventually picked up the uncut sausage with her fingers. NA-K asked if she wanted anything more to eat, poured apple juice, and walked away. R49 ate some bites of scrambled eggs and some of the pieces dropped onto the towel covering her clothing. R49 picked up the dropped pieces of egg and placed them on her plate. R49 ate all of the food and beverages served at the meal.

R49's quarterly Minimum Data Set dated 3/1/17, indicated R49 required limited staff assistance for eating, with R49 being highly involved in the activity. Staff provided guidance of maneuvering of limbs or other non-weight bearing assistance. R49's current careplan directed staff to assist the resident with meal set-up, cutting food into small pieces, and to provide supervision with all meals. Staff were to provide as much assistance as R49 required at mealtime.

On 4/13/17, at 10:33 a.m. the assistant director of nursing (ADON) stated she did not consider eating with fingers to be dignified. The ADON stated staff should have asked R49 if she wanted her food cut up and were expected to follow care plans because that was how the staff knew of how to provide care for their residents.

The facility's 1/12, Dignity policy "Staff are responsible for carrying out activities that assist the resident to maintain and enhance each residents self-esteem and self-worth. Examples of dignified care include...Offering assistance when and as needed."

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop policies and prrocedures to ensure resident rights are upheld for all residents in the facility. The

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21805	Continued From page 92 administrator or designee could educate all staff on resident rights and what to do when they believe those rights are violated. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21805		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter	21980		5/25/17

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21980	Continued From page 93 knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and designated State agency (SA) for 1 of 1 resident (R42) reviewed for abuse prohibition. Findings include: R42 sustained a bruise on 3/19/17, on her left knee measuring 4.3 centimeters (cm) long by 2.3 cm wide according to an incident report dated 3/29/17. The report indicated that on 3/19/17, nursing assistant (NA)-B noted the bruise and	21980	Corrected	

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reported it to registered nurse (RN)-A. R42 stated she was not sure how she sustained the bruise when RN-A asked how it had happened. However, R42 also stated she did not like being "grabbed out" of her wheelchair. A Witness/Observer Statement dated 3/19/17, by NA-B noted while assisting R42 with morning cares, she reported to NA-B she was upset over the way she was treated the previous evening. NA-B observed a bruise on R42's left knee which was reported to RN-A. NA-B was unsure whether RN-A had done anything with the report, therefore also reported it to his supervisor, NA-D who interviewed R42.

The facility was asked but could not provide evidence the administrator had immediately been notified of the allegation by R42, and had not been notified three days later on 3/22/17. LSW-A submitted at report to the SA on 3/22/17.

NA-B was interviewed on 4/12/17, at 10:00 a.m. and stated that on the morning of NA-B stated on the morning of 3/19/17, R42 told him she had a bruise on her left knee and was upset about her cares the night before, explaining the NA's were abrupt. I reported it immediately to RN-A and then to NA-D.

During an interview conducted on 4/12/17, at 9:19 a.m. RN-A stated he did not remember being informed of a bruise on R42 at any time.

During an interview conducted on 4/13/17, at 8:16 a.m. the DON stated she was the nurse on call the night the incident occurred and was reported to me on 3/19/17, by NA-D and was not reported to the MDH until 3/22/17. We have since changed our process regarding reporting incidents to the MDH. We should have reported it right away to

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the DON, Executive Director and the MDH which was not done. The facility could not provide documentation as to the nurse on call being notified.

During an interview on 4/11/17, at 1:14 p.m. R42 stated she was attacked sometime last winter outside. It was younger girls and they climbed up on me and hit my legs. They were nasty young people. I felt panicky as I had never been attacked before. There may have been three people. I reported it right away to RN-A.

During an interview on 4/13/17, at 12:02 p.m. Executive Director stated he did not recall if he was apprised of the incident to R42 which occurred on 3/19/17, but he did remember the incident. He further stated in this type of incident the facility is to call the nurse on call and they should contact the DON, LSW and myself. We then discuss it and determine if it needs to reported to the MDH.

During an interview on 4/13/17, at 1:04 p.m. Executive Director stated he could not confirm or deny if he had been notified of the incident involving R42 on 3/19/17, but the policy is to report incidents like this within 24 hours and that was not done.

During an interview on 4/12/17, at 9:25 a.m. LSW-B stated it was my understanding that a NA reported a bruise to R42's left knee on 3/19/19, and I was notified on 3/22/17. The facility policy indicates that if a bruise is noted the staff would notify LSW or the DON to start an investigation and that did not happen in this instance.

Based on interview and document review, the facility failed to immediately report injuries of

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unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1 resident (R54) incident reports reviewed.

Findings include:

R54 reported she had been abused at the facility when interviewed on 4/11/17, at 8:36 a.m. R54 alleged her roommate, R74 began hitting her and being physically abusive. R54 immediately reported it to a nurse. R54 moved to a different room for the weekend and then R74 was moved to a different room the following Monday.

R54's medical diagnoses on the admission record included anxiety disorder, major depressive disorder, borderline personality disorder, bipolar disorder. R54's minimum data set (MDS) from 3/7/17, identified her to be cognitively intact. The care plan printed 4/12/17, and provided by the facility as current addressed R54 being a vulnerable adult including the following interventions: Remove from potentially abusive situations, observe for and implement interventions to minimize and prevent re-occurrence, remove individuals to rooms or private areas for persistent &/or inappropriate behaviors.

The incident documented in progress note from care center dated 3/31/17, identified "Resident had moved to room 223 and will be staying over the weekend for her safety. Resident's roommate was verbal/physical aggression toward her, and for the concerns of her safety, the RN on call agreed to place her to 223 temporary."

An investigative report provided by the facility identified resident to resident abuse. The incident occurred on 3/31/17, and was reported to the

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21980	Continued From page 97 state agency on 4/1/17, by licensed social worker (LSW)-A. R54 stated R74 backed her into a corner, hit her and tried to punch her. R54 ran out of the room to alert the nurses. R74 tried to hit staff members as well. No injuries noted to R54. R54 moved to another room for the weekend, on Monday when private room available R74 was moved to a private room. No further incidences noted. On 4/13/17, at 10:48 a.m. the director of nursing (DON) stated registered nurse (RN)-E let the her know immediately about this abuse incident and LSW-A was called. LSW-A was not able to get the report filed due to internet issues, however she was called immediately regarding this abuse incident. The abuse incident was reported to the state agency the next morning. The DON stated the facility recently changed abuse reporting. Nurses should the call on-call nurse and the on-call nurse calls everyone else like the DON, administrator, social worker, MD, etc. The DON and LSW-A will collaborate on if they should report abuse incident to the state agency. LSW-A will typically be the one to submit abuse report. The DON stated they report abuse incidents as soon as possible. Resident/client/participant protection policy and procedure for the facility dated as last revised in 12/12, stated employees must always report abuse immediately to the supervisor or the building supervisor. The DON will be contacted per protocol and will involve LSW in decision making and will be reported to the state reporting agency in accordance to the state law. The policy also identified if the resident to resident altercation was a willful act, the resident's intent was to cause harm or wanted to hurt the other individual, a willful infliction of injury this	21980		

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altercation should then be reported, even if there is no injury. The facility must minimize and monitor to prevent reoccurrence.

The policy also identified employees must always report alleged abuse/neglect immediately to the Supervisor or the Building Supervisor. The Executive Director/ or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substantiated, it will be reported to the registry or licensing board.

Based on interview and record review the facility failed to complete criminal background checks on new hires for one of five employees (DA-A) reviewed.

Findings include:

During a review of employee records and interview with human resource (HR) director on 4/12/17, at 8:36 a.m. one employee/dietary aide (DA)-A, whose date of hire was 3/9/17, did not have a completed background check in the employee file. DA-A was on the schedule and had worked in the facility. DA-A had not been supervised or with another staff person at all times. HR explained the "expectation is to have the background completed for all staff. I can see that I will need to do an audit to make sure this was done". At 4/12/17 11:01 a.m. HR reported this employee was removed from the schedule pending her completed background check.

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21980	Continued From page 99 The policy "Pre-Employment Background Screening", revised 7/1/12, identified potential employees would receive job offers contingent upon the satisfactory completion of a background screening. SUGGESTED METHOD OF CORRECTION: The administrator and/or designee could provide education to facility staff on reporting potential resident neglect to the state agency immediately. The administrator and/or designee could develop monitoring systems to ensure ongoing compliance and share those results with the QA/QI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them.	22000		5/25/17

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The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

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

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to implement their policy to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1 resident (R42).

Corrected

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22000	Continued From page 101 Findings include: The facility's Policy and Procedure for: Resident/client/participant Protection - selection Reporting and Response, revised 12/12, read: Employees must always report alleged abuse/neglect (i.e. incidents, mistreatment, abuse, neglect, injuries of unknown origin, and misappropriation of resident/client/participant property) immediately to the Supervisor or the Building Supervisor. The Executive Director/ or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. Director of Nursing will be contacted per protocol and will involve Social services or designee. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substantiated, it will be reported to the registry or licensing board. Documentation: Include who was notified and the time the notification occurred. Include social services or designee in the notification. An incident report dated 3/29/17, indicated on 3/19/17, nursing assistant (NA)-B noted R42 had a bruise on her left knee and reported it to registered nurse (RN)-A. Bruise measured 4.3 centimeters (cm) long by 2.3 cm wide. When R42 was asked by nurse how it could have happened she stated she was not sure how it happened. R42 also stated she did not like being grabbed out of her wheelchair. A Witness/Observer Statement dated 3/19/17, NA-B noted while doing morning cares on R42, she related that she was upset with previous evening's treatment after	22000		

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supper. A bruise was noted on R42's left knee which was reported to RN-A but NA-B was unsure whether RN-A followed through. NA-B then reported incident to his supervisor NA-D who consulted with R42.

The facility could not provide any evidence of the director of nursing (DON), social services (SS) or Executive Director being notified of incident until 3/22/17. The incident was submitted to the Minnesota Department of Health (MDH) on 3/22/17, by SS-A.

During an interview conducted on 4/12/20, at 10:00 a.m. NA-B stated on the morning of 3/19/17, R42 told him she had a bruise on her left knee and was upset about her cares the night before and the NA's were abrupt. I reported it immediately to RN-A and then to NA-D.

During an interview conducted on 04/12/17, at 9:19 a.m. RN-A stated he did not remember being told about a bruise on R42 at any time.

During an interview conducted on 4/13/17, at 8:16 a.m. DON stated she was the nurse on call the night the incident occurred and was reported to me on 3/19/17, by NA-D and was not reported to the MDH until 3/22/17. We have since changed our process regarding reporting incidents to the MDH. We should have reported it right away to the DON, Executive Director and the MDH which was not done. The facility could not provide documentation as to the nurse on call being notified.

During an interview on 4/11/17, at 1:14 p.m. R42 stated she was attacked sometime last winter outside. It was younger girls and they climbed up on me and hit my legs. They were nasty young

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	00740	A. BUILDING: ____ B. WING ____	04/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDINA CARE & REHAB CENTER	**6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 103	22000		

people. I felt panicky as I had never been attacked before. There may have been 3 people. I reported it right away to RN-A.

During an interview on 4/13/17, at 12:02 p.m. Executive Director stated he did not recall if he was apprised of the incident to R42 which occurred on 3/19/17, but he did remember the incident. He further stated in this type of incident the facility is to call the nurse on call and they should contact the DON, SS and myself. We then discuss it and determine if it needs to reported to the MDH.

During an interview on 4/13/17, at 1:04 p.m. Executive Director stated he could not confirm or deny if he had been notified of the incident involving R42 on 3/19/17, but the policy is to report incidents like this within 24 hours and that was not done.

During an interview on 4/12/17, at 9:25 a.m. SS-B stated it was my understanding that a NA reported a bruise to R42's left knee on 3/19/19, and I was notified on 3/22/17. The facility policy indicates that if a bruise is noted the staff would notify SS or DON to start an investigation and that did not happen in this instance.

Based on interview and document review and interview, the facility failed to implement their policy to immediately report injuries of unknown origin or allegations of neglect or abuse to the facility administrator and state agency for 1 of 1 resident (R54) incident reports reviewed.

Findings include:

The facility Resident/Client/Participant Protection policy and procedure dated as last revised in

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22000	Continued From page 104	22000		

12/12, stated employees must always report abuse immediately to the supervisor or the building supervisor. The DON will be contacted per protocol and will involve LSW in decision making and will be reported to the state reporting agency in accordance to the state law. The policy also identified if the resident to resident altercation was a willful act, the resident's intent was to cause harm or wanted to hurt the other individual, a willful infliction of injury this altercation should then be reported, even if there is no injury. The policy further identified it was possible for a willful act to be committed by someone with dementia. The facility must minimize and monitor to prevent reoccurrence.

The policy also identified employees must always report alleged abuse/neglect immediately to the Supervisor or the Building Supervisor. The Executive Director/ or designated representative must be contacted immediately by Supervisor or reporter regarding all allegations of abuse/neglect. Immediate reporting may be reported via voice mail, answering machine, or fax. Document date and time of notification. If there is suspicion that abuse occurred, it will be reported to the State Reporting Agency in accordance with state law. If the abuse is substantiated, it will be reported to the registry or licensing board.

R54 reported she had been abused at the facility when interviewed on 4/11/17, at 8:36 a.m. R54 alleged her roommate, R74 began hitting her and being physically abusive. R54 immediately reported it to a nurse. R54 moved to a different room for the weekend and then R74 was moved to a different room the following Monday.

R54's medical diagnoses on the admission record

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22000	Continued From page 105 included anxiety disorder, major depressive disorder, borderline personality disorder, bipolar disorder. R54's minimum data set (MDS) from 3/7/17, identified her to be cognitively intact. The current care plan provided as current addressed R54 being a vulnerable adult including the following interventions: Remove from potentially abusive situations, observe for and implement interventions to minimize and prevent re-occurrence, remove individuals to rooms or private areas for persistent &/or inappropriate behaviors. The incident documented in progress note from care center dated 3/31/17, identified "Resident had moved to room 223 and will be staying over the weekend for her safety. Resident's roommate was verbal/physical aggression toward her, and for the concerns of her safety, the RN on call agreed to place her to 223 temporary." An investigative report provided by the facility identified resident to resident abuse. The incident occurred on 3/31/17, and was reported to the state agency on 4/1/17, by licensed social worker (LSW)-A. R54 stated R74 backed her into a corner, hit her and tried to punch her. R54 ran out of the room to alert the nurses. R74 tried to hit staff members as well. No injuries noted to R54. R54 moved to another room for the weekend, on Monday when private room available R74 was moved to a private room. No further incidences noted. On 4/13/17, at 10:48 a.m. the director of nursing (DON) stated registered nurse (RN)-E let the her know immediately about this abuse incident and LSW-A was called. LSW-A was not able to get the report filed due to internet issues, however she was called immediately regarding this abuse	22000		

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incident. The abuse incident was reported to the state agency the next morning. The DON stated the facility recently changed abuse reporting. Nurses should the call on-call nurse and the on-call nurse calls everyone else like the DON, administrator, social worker, MD, etc. The DON and LSW-A will collaborate on if they should report abuse incident to the state agency. LSW-A will typically be the one to submit abuse report. The DON stated they report abuse incidents as soon as possible.

SUGGESTED METHOD FOR CORRECTION: The administrator or designee(s) could develop systems to ensure the policies related to abuse/neglect are appropriately implemented. The administrator or designee could educate all staff on those systems. The administrator or designee could develop monitoring systems to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.