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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: C6FZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**
2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY **01/12/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (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
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 01/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/12/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245360
January 15, 2016

Mr. James Ingersoll, Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, Minnesota 56273

Dear Mr. Ingersoll:

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

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

Effective January 4, 2016 the above facility is certified for or recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

MDH
Minnesota Department of Health

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 15, 2016

Mr. James Ingersoll, Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, Minnesota 56273

RE: Project Number S5360027

Dear Mr. Ingersoll:

On December 28, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of December 28, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 20, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on October 20, 2015, that included an investigation of complaint number H5360015, and lack of verification of substantial compliance with the health deficiencies at the time of our December 28, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 12, 2016, 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 October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 20, 2015, as of January 4, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our

letter of December 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 20, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 20, 2016, is to be rescinded.

In our letter of December 28, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 4, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On January 11, 2016,

I, JAMES INGERSOLL, CEO/ADMINISTRATOR, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated January 11, 2016 and licensing orders issued to:

Benedictine Living Community Of New London
100 Glen Oaks Drive
New London, MN 56273

The Penalty Assessments and licensing orders attached hereto have been corrected as of 1-11-16.

Signed: _____, CEO/ADMINISTRATOR, Date 1-11-16
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On January 11, 2016,

I, Austin Fry, Nurse Evaluator II, of the Division of
Compliance Monitoring, Minnesota Department of Health, delivered the Notice of Penalty Assessment dated January 11, 2016 and issued to:

Benedictine Living Community Of New London
100 Glen Oaks Drive
New London, MN 56273

The Notice of Penalty Assessment was handed to JAMES INGERSOLL,
(Name)(Please Print)
ADMINISTRATOR, Date 1/11/16
(Title)(Please Print)

Signed: _____, RN HSE NEII, Date 1/11/16
(Name)(Please Print) (Title)(Please Print)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on January 11, 2016.
January 11, 2016

Mr. James Ingersoll, Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, Minnesota 56273

Re: Project # S5360027

Dear Mr. Ingersoll:

On December 16, 2015, 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 October 20, 2015 with orders received by you on November 6, 2015.

State licensing orders issued pursuant to the last survey completed on October 20, 2015, found not corrected at the time of this December 16, 2015 revisit and subject to penalty assessment are as follows:

20565 -- MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use	- $300
20895 -- MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion	- $350

The details of the violations noted at the time of this revisit completed on December 16, 2015 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, sign and date this form or return it to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $650.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until written notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, 3333 W Division, #212 St Cloud Mn 56301.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing	1/12/2016

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**01/04/2016**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	**01/04/2016**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	01/15/2016	33925	01/12/2016

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/20/2015				

AH Form Approved
1/15/2016

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00314	A. Building B. Wing	1/12/2016

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**01/04/2016**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp. 2.B** LSC	**01/04/2016**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	01/15/2016	33925	01/12/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/20/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C6FZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**
2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY **12/16/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (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
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 01/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/12/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/02/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 15, 2016

Mr. James Ingersoll, Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, Minnesota 56273

RE: Project Number S5360027

Dear Mr. Ingersoll:

On December 28, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016. (42 CFR 488.417 (b))

Also, we notified you in our letter of December 28, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 20, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on October 20, 2015, that included an investigation of complaint number H5360015, and lack of verification of substantial compliance with the health deficiencies at the time of our December 28, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On January 12, 2016, 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 October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 4, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 20, 2015, as of January 4, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our

letter of December 28, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 20, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 20, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 20, 2016, is to be rescinded.

In our letter of December 28, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 20, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on January 4, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

Electronically delivered
December 28, 2015

Mr James Ingersoll, Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, Minnesota 56273

RE: Project Number S5360027

Dear Mr. Ingersoll:

On November 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 20, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 13, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on October 20, 2015.

However, compliance with the health deficiencies issued pursuant to the October 20, 2015 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On November 9, we also informed you that if your facility had not achieved substantial compliance by November 29, 2015, the Department of Health would impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January

20, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 20, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 20, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Benedictine Living Community Of New London is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 20, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Jan.Suzuki@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division

330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	**100 GLEN OAKS DRIVE NEW LONDON, MN 56273**

(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 An onsite post certification revisit (PCR) was completed on December 15-16, 2015. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and/or new tags were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 282} SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure staff followed the plan of care for 3 of 4 residents (R3, R50 and R35) reviewed for restorative nursing services. In addition, the facility failed to follow the plan of care for 1 of 3 residents (R53) observed during routine morning cares.	{F 282}	Plan of correction F282 A: The residents identified, as well as all residents receiving restorative nursing services, are receiving rehab/ROM services as per their plan of care. All residents are receiving proper assistance with their ADL's as per their	1/4/16

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

Electronically Signed

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 282}	Continued From page 1 Findings include: RESTORATIVE NURSING SERVICES R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 had moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff members for transfers. Further, the MDS identified R3 had bilateral mobility impairments to the lower extremities, and received no days of completed range of motion (ROM). R3's care plan dated 11/25/15, identified an intervention for staff to complete ankle and foot passive range of motion (PROM) including dorsiflexion, plantarflexion, with 15 reps each foot, heel cord stretches up to three times weekly as R3 tolerates. R3's Restorative Flowsheets dated 10/1/15 - 12/15/15, identified the ordered PROM had been documented as completed as follows: - October 2015 4 of 13 opportunities - November 2015 8 of 13 opportunities - December 2015 2 of 7 opportunities When interviewed on 12/15/15, at 9:37 a.m. restorative/nursing assistant (NA)-A stated she continues to be pulled from restorative to work as a NA on the floor. At times, she will be pulled to the floor until there is a replacement and she can then resume the restorative duties. Two additional NAs are trained for restorative, and they are also getting pulled to the floor at times. When interviewed on 12/16/15, at 12:37 p.m. NA-A reviewed R3's Restorative Flowsheets, and	{F 282}	plans of care. B: The care plans of all residents receiving rehab/ROM services were reviewed and updated as needed and assessed to match the treatment records for all residents receiving restorative nursing services. Review of our current system for communicating care needs to our CNA's was conducted and changes were implemented to assure each client is receiving assistance with their ADL's as per their plan of care. C: Detailed reviews and audits of the restorative treatment records have been conducted to assure each resident is receiving their rehab/ROM services as per their plan of care. Weekly meetings have been established with a rehab team including the RN Case Managers, the facility COTA and the primary restorative aide. The interim DON also attends these meetings. These meetings include the review of each resident's participation and progress with restorative nursing as well as a detailed check to assure accuracy with the resident's plan of care and treatment record. A new "care sheet" was created for the CNAs to assure each resident is receiving the care they need as per their plan of care. This care sheet includes detailed information about each resident's ADL need as per their care plan. D: Weekly restorative meetings will continue to allow ongoing review of each resident's restorative nursing plan by	

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{F 282}	Continued From page 2 verified if the dates are left blank R3 did not receive PROM. When interviewed on 12/16/15, at 1:19 p.m. DON stated changes have been made to the restorative program, and if they are short NA's on the floor, a restorative NA may be pulled to assist residents to get up for the day, then they return to provide restorative services. DON was unaware that rehab was getting pulled more in December, and restorative services were not being completed as identified by the care plan. R50's quarterly MDS, dated 10/22/2015, included diagnoses of right-sided hemiparesis due to cardio vascular accident (stroke), and indicated she required extensive assistance of two persons for bed mobility and transfers. The MDS also indicated R50 was severely, cognitively impaired. R50's care plan, updated 11/2/2015 included interventions to prevent contractures, which directed restorative nursing staff to complete daily hamstring and adductor stretches, and ROM (range of motion) to RUE (right upper extremity). R50s restorative flowsheet included the orders: Hamstring and Adductor stretches per therapy recommendations as resident tolerates; and RUE to shoulder, elbows and wrist in all planes to reduce contracture per therapy recommendations. A review of R50's restorative flowsheets indicated the following: -October 2015 14 of 31 opportunities (no documentation of any kind on 17 days) -November 2015 23 of 30 opportunities (no	{F 282}	using a team approach. Audits of the restorative treatment records will be done weekly x4 then monthly ongoing to assure all residents area receiving their rehab/ROM services as per their plan of care. These audits and their findings will be discussed up to monthly at the QA meeting for determination of ongoing need. DON/Designee will monitor/review audits to ensure completion and compliance. Progress will be reviewed at QA meetings. We continue with ongoing monitoring and education with CNAs regarding the importance of following each resident's plan of care. E: Corrected 1-4-16	

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{F 282}	Continued From page 3 documentation x 2 days, "no rehab" x 6 days) -December 2015 8 of 15 opportunities ("pulled" [no rehab] x 7 days During an interview on 12/15/15 at 9:37 a.m.,nursing assistant (NA)-A stated she "continues to be pulled" from restorative to work as a NA on the floor. NA-A said at time she will be pulled to the floor until there is a replacement, and she can then resume the restorative duties. NA-A also said "two additional NAs are trained for restorative," and they are also getting pulled to the floor at times. In follow up interview on 12/16/15, at 12:37 p.m., NA-A reviewed R50's Restorative Flowsheets, and verified the dates marked "Pulled." NA-A said R50's did not receive daily hamstring and adductor stretches, and ROM services, and in December received only 8 of 15 opportunities. During an interview on 12/16/15 at 1:45 p.m. registered nurse (RN)- B said R50's "exercises and stretches" were done by Rehab only. R35's quarterly Minimum Data Set (MDS), dated 9/25/2015, included diagnoses of Parkinson's, and identified R35 required extensive assistance with bed mobility and transfers, and also indicated she walked 1-2 times during the reference period. R35's care plan identified impaired mobility, and included interventions to meet the goal to participate with transfers and remain able to propel self. The care directed "NuStep [a seated exercise machine] up to 3x [three times] a week for 15 min [minutes].	{F 282}		

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{F 282}	Continued From page 4 A review of the medical record and restorative nursing flow sheets for December 2015 did not indicate R35 had ever received the NuStep exercise therapy three times a week as identified by the care plan. During an interview on 12/16/15 at 12:52 p.m., NA-A stated she was the restorative aide, that assists the residents with the NuStep exercises but R35 "has never been on the NuStep list." Even though R35 care plan identified she was to receive the NuStep exercises 3 times a week, the facility has not implemented the care plan. MORNING CARES R53's quarterly Minimum Data Set, dated 9/4/2015, identified diagnoses which included dementia and history of cardio-vascular accident (stroke), and further indicated R53 required extensive assistance to complete personal hygiene, including brushing teeth. The MDS also indicated R53 was moderately, cognitively impaired. The care plan, dated 12/14/2015, identified R53 required extensive assistance of 1-2 staff, as condition requires, "with dressing, grooming, bathing and personal hygiene." During observation on 12/16/2015 at 8:03 a.m., nursing assistant (NA)-C entered R53's room to begin morning cares. At 8:07 a.m. NA-D entered the room to assist R53, and completed washing R53's upper and lower body, including face, hands, arms and underarms. Next, NA-C assisted NA-D to roll and reposition in the bed, while changing his incontinent product. NA-D and NA-E then assisted R53 to dress. At 8:18 a.m.,	{F 282}		

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{F 282}	Continued From page 5 NA-C and NA-D transferred R53 from his bed into his Broda chair (a type of wheel chair). Neither oral care, nor shaving assistance was provided for R53 during this observation. At 8:20 a.m., NA-D pushed R53's wheel chair into the dining area and was served breakfast. In an interview on 12/16/2015 at 9:32 a.m. family member (FM)-A stated when she came to facility, R53 was "frequently unkempt" because he was unshaven, often had food on his shirts after meals, and "did not have oral cares completed." FM-A stated that when in the facility, she often did some of R53's cares. Presently FM-A stated she was not able to get to the facility as often as she has in the past, and when she sees R53 unshaven, or not having teeth care, "I'm very upset." Following the breakfast meal at 9:55 a.m. on 10/16/2015, R53 was transferred from the wheel chair into bed, his incontinent brief was checked and found dry, and was positioned in bed. The NA-D did not offer or provide shaving or oral cares for R53 during this time. In an interview on 12/16/2015 at 1:55 p.m., NA- D stated R53 was not shaved and "did not receive any oral cares either." NA-D said oral care and shaving was "usually done when a resident gets up and before breakfast" or right after breakfast. NA-D said providing oral cares was a part of "personal hygiene and grooming, really for every resident," and there was "no reason" why R53's morning cares were not provided. During an interview on 12/16/2015 at 2:18 p.m., the director of nursing (DON) stated that "[R53's] care plan needed to be followed." The DON said	{F 282}		

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{F 282}	Continued From page 6 she "would take note of R53's concern, and also that she would expect the same following of resident needs and care plans "for all the residents." Resident #53 A facility policy titled Using the Care Plan, dated August 2006, identified the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.	{F 282}		
{F 318} SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to consistently provide range of motion (ROM) services for 2 of 4 residents (R3 and 50) in the sample reviewed for restorative nursing services. Findings include: R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 had moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff members for transfers. Further, the MDS	{F 318}	Plan of Correction F 318 A: The residents identified as well as all residents care planned to receive rehab/ROM services are receiving rehab/ROM services as per their plan of care. B: All restorative treatment records and care plans were reviewed for all residents receiving rehab/ROM services. C: Education provided to all staff on the importance of not pulling the rehab aides	1/4/16

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{F 318}	Continued From page 7 identified R3 had bilateral mobility impairments to the lower extremities, and received no days of completed range of motion (ROM). R3's care plan dated 11/25/15, identified an intervention for staff to complete ankle and foot passive range of motion (PROM) including dorsiflexion, plantarflexion, with 15 reps each foot, heel cord stretches up to three times weekly as R3 tolerates. R3's Restorative Flowsheet dated 1/23/15, identified an order for ankle and foot PROM dorsiflexion (toes upward), plantarflexion (toes downward) 15 reps each foot. Heel cord stretches (toes upward and hold 30 seconds, three reps to each foot/ankle). Once a day Sunday, Tuesday, and Thursday, up to three times per week. Review of R3's Restorative Flowsheets dated 10/1/15 - 12/15/15, identified PROM had been documented as completed as follows: - October 2015 4 of 13 opportunities - November 2015 8 of 13 opportunities - December 2015 2 of 7 opportunities During an interview on 12/15/15, at 9:37 a.m. restorative/nursing assistant (NA)-A stated she continues to be pulled from restorative to work as a NA on the floor. At times, she will be pulled to the floor until there is a replacement and she can then resume the restorative duties. Two additional NAs are trained for restorative, and they are also getting pulled to the floor at times. When interviewed on 12/16/15, at 12:37 p.m. NA-A reviewed R3's Restorative Flowsheets, and	{F 318}	to the floor. Additional staff were trained in the rehab aide role. Weekly meetings were formed and have been held consistently to discuss and review all residents' participation and progress with restorative nursing. Attending this meeting weekly are the RN Case Managers, the facility COTA and the primary rehab aide. The interim DON also attends these meetings as able. D: The staffing coordinator continues to assure there is a rehab aide at least 5 days per week. The restorative/Rehab team will continue to meet on a weekly basis ongoing. Audits of the restorative treatment records of all residents participating with rehab will be done weekly x4 then monthly ongoing to assure that all residents who receive rehab/ROM services are receiving these services as care planned. These audits and their findings will be discussed at the QA meetings up to monthly for determination of their ongoing need. DON/Designee will monitor/review audits to ensure completion and compliance. Progress will be reviewed at QA meetings. E: Corrected 1-4-16	

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{F 318}	Continued From page 8	{F 318}		

stated if the dates were left blank, R3 did not receive PROM. She stated not all NAs are crossed trained to provide the restorative services. A restorative committee meets weekly on Wednesday, including herself, occupational therapy assistant (OTA), and registered nurse (RN)-A. She also stated the director of nursing (DON) or charge nurses are in charge of the restorative program.

When interviewed on 12/16/15, at 12:55 p.m. OTA stated she has covered on the floor to provide restorative services once when they were short staffed. She also verified the committee meeting only started two weeks ago.

R50's quarterly MDS, dated 10/22/2015, included severe cognitive impairment, and had a diagnoses of right-sided hemiparesis due to cardio vascular accident (stroke), and required extensive assistance of bed mobility and transfers.

R50's care plan, updated 11/2/2015 included interventions to prevent contractures, which directed restorative nursing staff to complete daily hamstring and adductor stretches, and ROM (range of motion) to RUE (right upper extremity).

R50's restorative flowsheets identified "Hamstring and Adductor stretches per therapy recommendations as resident tolerates, once per day." Range of motion, "RUE [right upper extremity] to shoulder, elbow and wrist in all planes to reduce contracture per therapy recommendations, one per day."

A review of R50's restorative flowsheets from October to December 15, 2015 identified the

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{F 318}	Continued From page 9 following rehab was completed: -October 2015 14 of 31 opportunities (no documentation on 17 days) -November 2015 23 of 30 opportunities (no documentation x 2 days, "no rehab" x 6 days) -December 2015 8 of 15 opportunities ("pulled" [no rehab] x 7 days During an interview on 12/15/15 at 9:37 a.m.,nursing assistant (NA)-A stated she "continues to be pulled" from restorative to work as a NA on the floor. NA-A said at time she will be pulled to the floor until there is a replacement, and she can then resume the restorative duties. NA-A also said "two additional NAs are trained for restorative," and they are also getting pulled to the floor and they were unable to provide rehab during this time. In follow up interview on 12/16/15, at 12:37 p.m., NA-A reviewed R50's Restorative Flowsheets, and verified the dates marked "Pulled," R50 had not received the daily hamstring, adductor stretches, and ROM services. In December R50 only received 8 of 15 opportunities for rehab. During an interview on 12/16/15 at 1:45 p.m. registered nurse (RN)- B said R50's "exercises and stretches" were done by Rehab only. When interviewed on 12/16/15, at 1:19 p.m. DON stated changes have been made to the restorative program, with four additional staff being trained in. She verified when the NAs are short on the floor, the restorative NA may be pulled to assist in getting residents up for the day, and they return to provide restorative services. DON also stated the RN case managers were responsible to review the flowsheets and	{F 318}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	R 12/16/2015

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{F 318}	Continued From page 10 progress of residents weekly. The DON was unaware that nursing rehab was getting pulled more in December, and restorative services were not being completed for the residents as directed.	{F 318}		

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **11/19/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/01/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **11/30/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/30/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **11/30/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **11/30/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/30/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **11/30/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	12/30/2015	32613	12/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/20/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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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: An onsite state licensing revisit was completed on December 15-16, 2015. Licensing orders for 0565 and 0895, were not corrected. These uncorrected orders will remain in effect and will be reviewed at the next onsite visit, all uncorrected orders will be reviewed for possible	{2 000}		

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{2 000}	Continued From page 1 penalty assessments.	{2 000}		
{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: Uncorrected based on the following findings. The original licensing order issued on October 20, 2015, will remain in effect. Penalty assessment issued. Based on interview and document review, the facility failed to ensure staff followed the plan of care for 3 of 4 residents (R3, R50 and R35) reviewed for restorative nursing services. In addition, the facility failed to follow the plan of care for 1 of 3 residents (R53) observed during routine morning cares. Findings include: RESTORATIVE NURSING SERVICES R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 had moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff members for transfers. Further, the MDS identified R3 had bilateral mobility impairments to the lower extremities, and received no days of completed range of motion (ROM).	{2 565}	Plan of correction F282 A: The residents identified, as well as all residents receiving restorative nursing services, are receiving rehab/ROM services as per their plan of care. All residents are receiving proper assistance with their ADL's as per their plans of care. B: The care plans of all residents receiving rehab/ROM services were reviewed and updated as needed and assessed to match the treatment records for all residents receiving restorative nursing services. Review of our current system for communicating care needs to our CNA's was conducted and changes were implemented to assure each client is receiving assistance with their ADL's as per their plan of care. C: Detailed reviews and audits of the restorative treatment records have been conducted to assure each resident is receiving their rehab/ROM services as per	1/4/16

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{2 565}	Continued From page 2 R3's care plan dated 11/25/15, identified an intervention for staff to complete ankle and foot passive range of motion (PROM) including dorsiflexion, plantarflexion, with 15 reps each foot, heel cord stretches up to three times weekly as R3 tolerates. R3's Restorative Flowsheets dated 10/1/15 - 12/15/15, identified the ordered PROM had been documented as completed as follows: - October 2015 4 of 13 opportunities - November 2015 8 of 13 opportunities - December 2015 2 of 7 opportunities When interviewed on 12/15/15, at 9:37 a.m. restorative/nursing assistant (NA)-A stated she continues to be pulled from restorative to work as a NA on the floor. At times, she will be pulled to the floor until there is a replacement and she can then resume the restorative duties. Two additional NAs are trained for restorative, and they are also getting pulled to the floor at times. When interviewed on 12/16/15, at 12:37 p.m. NA-A reviewed R3's Restorative Flowsheets, and verified if the dates are left blank R3 did not receive PROM. When interviewed on 12/16/15, at 1:19 p.m. DON stated changes have been made to the restorative program, and if they are short NA's on the floor, a restorative NA may be pulled to assist residents to get up for the day, then they return to provide restorative services. DON was unaware that rehab was getting pulled more in December, and restorative services were not being completed as identified by the care plan.	{2 565}	their plan of care. Weekly meetings have been established with a rehab team including the RN Case Managers, the facility COTA and the primary restorative aide. The interim DON also attends these meetings. These meetings include the review of each resident's participation and progress with restorative nursing as well as a detailed check to assure accuracy with the resident's plan of care and treatment record. A new "care sheet" was created for the CNAs to assure each resident is receiving the care they need as per their plan of care. This care sheet includes detailed information about each resident's ADL need as per their care plan. D: Weekly restorative meetings will continue to allow ongoing review of each resident's restorative nursing plan by using a team approach. Audits of the restorative treatment records will be done weekly x4 then monthly ongoing to assure all residents area receiving their rehab/ROM services as per their plan of care. These audits and their findings will be discussed up to monthly at the QA meeting for determination of ongoing need. DON/Designee will monitor/review audits to ensure completion and compliance. Progress will be reviewed at QA meetings. We continue with ongoing monitoring and education with CNAs regarding the importance of following each resident's plan of care. E: Corrected 1-4-16	

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{2 565}	Continued From page 3 R50's quarterly MDS, dated 10/22/2015, included diagnoses of right-sided hemiparesis due to cardio vascular accident (stroke), and indicated she required extensive assistance of two persons for bed mobility and transfers. The MDS also indicated R50 was severely, cognitively impaired. R50's care plan, updated 11/2/2015 included interventions to prevent contractures, which directed restorative nursing staff to complete daily hamstring and adductor stretches, and ROM (range of motion) to RUE (right upper extremity). R50s restorative flowsheet included the orders: Hamstring and Adductor stretches per therapy recommendations as resident tolerates; and RUE to shoulder, elbows and wrist in all planes to reduce contracture per therapy recommendations. A review of R50's restorative flowsheets indicated the following: -October 2015 14 of 31 opportunities (no documentation of any kind on 17 days) -November 2015 23 of 30 opportunities (no documentation x 2 days, "no rehab" x 6 days) -December 2015 8 of 15 opportunities ("pulled" [no rehab] x 7 days During an interview on 12/15/15 at 9:37 a.m.,nursing assistant (NA)-A stated she "continues to be pulled" from restorative to work as a NA on the floor. NA-A said at time she will be pulled to the floor until there is a replacement, and she can then resume the restorative duties. NA-A also said "two additional NAs are trained for restorative," and they are also getting pulled to the floor at times. In follow up interview on 12/16/15, at 12:37 p.m.,	{2 565}		

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{2 565}	Continued From page 4 NA-A reviewed R50's Restorative Flowsheets, and verified the dates marked "Pulled." NA-A said R50's did not receive daily hamstring and adductor stretches, and ROM services, and in December received only 8 of 15 opportunities. During an interview on 12/16/15 at 1:45 p.m. registered nurse (RN)- B said R50's "exercises and stretches" were done by Rehab only. R35's quarterly Minimum Data Set (MDS), dated 9/25/2015, included diagnoses of Parkinson's, and identified R35 required extensive assistance with bed mobility and transfers, and also indicated she walked 1-2 times during the reference period. R35's care plan identified impaired mobility, and included interventions to meet the goal to participate with transfers and remain able to propel self. The care directed "NuStep [a seated exercise machine] up to 3x [three times] a week for 15 min [minutes]. A review of the medical record and restorative nursing flow sheets for December 2015 did not indicate R35 had ever received the NuStep exercise therapy three times a week as identified by the care plan. During an interview on 12/16/15 at 12:52 p.m., NA-A stated she was the restorative aide, that assists the residents with the NuStep exercises but R35 "has never been on the NuStep list." Even though R35 care plan identified she was to receive the NuStep exercises 3 times a week, the facility has not implemented the care plan. MORNING CARES	{2 565}		

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{2 565}	Continued From page 5 R53's quarterly Minimum Data Set, dated 9/4/2015, identified diagnoses which included dementia and history of cardio-vascular accident (stroke), and further indicated R53 required extensive assistance to complete personal hygiene, including brushing teeth. The MDS also indicated R53 was moderately, cognitively impaired. The care plan, dated 12/14/2015, identified R53 required extensive assistance of 1-2 staff, as condition requires, "with dressing, grooming, bathing and personal hygiene." During observation on 12/16/2015 at 8:03 a.m., nursing assistant (NA)-C entered R53's room to begin morning cares. At 8:07 a.m. NA-D entered the room to assist R53, and completed washing R53's upper and lower body, including face, hands, arms and underarms. Next, NA-C assisted NA-D to roll and reposition in the bed, while changing his incontinent product. NA-D and NA-E then assisted R53 to dress. At 8:18 a.m., NA-C and NA-D transferred R53 from his bed into his Broda chair (a type of wheel chair). Neither oral care, nor shaving assistance was provided for R53 during this observation. At 8:20 a.m., NA-D pushed R53's wheel chair into the dining area and was served breakfast. In an interview on 12/16/2015 at 9:32 a.m. family member (FM)-A stated when she came to facility, R53 was "frequently unkempt" because he was unshaven, often had food on his shirts after meals, and "did not have oral cares completed." FM-A stated that when in the facility, she often did some of R53's cares. Presently FM-A stated she was not able to get to the facility as often as she has in the past, and when she sees R53 unshaven, or not having teeth care, "I'm very	{2 565}		

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{2 565}	Continued From page 6 upset." Following the breakfast meal at 9:55 a.m. on 10/16/2015, R53 was transferred from the wheel chair into bed, his incontinent brief was checked and found dry, and was positioned in bed. The NA-D did not offer or provide shaving or oral cares for R53 during this time. In an interview on 12/16/2015 at 1:55 p.m., NA- D stated R53 was not shaved and "did not receive any oral cares either." NA-D said oral care and shaving was "usually done when a resident gets up and before breakfast" or right after breakfast. NA-D said providing oral cares was a part of "personal hygiene and grooming, really for every resident," and there was "no reason" why R53's morning cares were not provided. During an interview on 12/16/2015 at 2:18 p.m., the director of nursing (DON) stated that "[R53's] care plan needed to be followed." The DON said she "would take note of R53's concern, and also that she would expect the same following of resident needs and care plans "for all the residents." Resident #53 A facility policy titled Using the Care Plan, dated August 2006, identified the care plan shall be used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident.	{2 565}		
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities	{2 895}		1/4/16

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{2 895}	Continued From page 7 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on October 20, 2015, will remain in effect. Penalty assessment issued. Based on interview and document review the facility failed to consistently provide range of motion (ROM) services for 2 of 4 residents (R3 and 50) in the sample reviewed for restorative nursing services. Findings include: R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 had moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff members for transfers. Further, the MDS identified R3 had bilateral mobility impairments to the lower extremities, and received no days of completed range of motion (ROM). R3's care plan dated 11/25/15, identified an intervention for staff to complete ankle and foot passive range of motion (PROM) including	{2 895}	Plan of Correction F 318 A: The residents identified as well as all residents care planned to receive rehab/ROM services are receiving rehab/ROM services as per their plan of care. B: All restorative treatment records and care plans were reviewed for all residents receiving rehab/ROM services. C: Education provided to all staff on the importance of not pulling the rehab aides to the floor. Additional staff were trained in the rehab aide role. Weekly meetings were formed and have been held consistently to discuss and review all residents' participation and progress with restorative nursing. Attending this meeting weekly are the RN Case Managers, the facility COTA and the primary rehab aide. The interim DON also attends these meetings as able. D: The staffing coordinator continues to	

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{2 895}	Continued From page 8 dorsiflexion, plantarflexion, with 15 reps each foot, heel cord stretches up to three times weekly as R3 tolerates. R3's Restorative Flowsheet dated 1/23/15, identified an order for ankle and foot PROM dorsiflexion (toes upward), plantarflexion (toes downward) 15 reps each foot. Heel cord stretches (toes upward and hold 30 seconds, three reps to each foot/ankle). Once a day Sunday, Tuesday, and Thursday, up to three times per week. Review of R3's Restorative Flowsheets dated 10/1/15 - 12/15/15, identified PROM had been documented as completed as follows: - October 2015 4 of 13 opportunities - November 2015 8 of 13 opportunities - December 2015 2 of 7 opportunities During an interview on 12/15/15, at 9:37 a.m. restorative/nursing assistant (NA)-A stated she continues to be pulled from restorative to work as a NA on the floor. At times, she will be pulled to the floor until there is a replacement and she can then resume the restorative duties. Two additional NAs are trained for restorative, and they are also getting pulled to the floor at times. When interviewed on 12/16/15, at 12:37 p.m. NA-A reviewed R3's Restorative Flowsheets, and stated if the dates were left blank, R3 did not receive PROM. She stated not all NAs are crossed trained to provide the restorative services. A restorative committee meets weekly on Wednesday, including herself, occupational therapy assistant (OTA), and registered nurse (RN)-A. She also stated the director of nursing (DON) or charge nurses are in charge of the	{2 895}	assure there is a rehab aide at least 5 days per week. The restorative/Rehab team will continue to meet on a weekly basis ongoing. Audits of the restorative treatment records of all residents participating with rehab will be done weekly x4 then monthly ongoing to assure that all residents who receive rehab/ROM services are receiving these services as care planned. These audits and their findings will be discussed at the QA meetings up to monthly for determination of their ongoing need. DON/Designee will monitor/review audits to ensure completion and compliance. Progress will be reviewed at QA meetings. E: Corrected 1-4-16	

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BENEDICTINE LIVING COMMUNITY OF NEW L	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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{2 895}	Continued From page 9 restorative program. When interviewed on 12/16/15, at 12:55 p.m. OTA stated she has covered on the floor to provide restorative services once when they were short staffed. She also verified the committee meeting only started two weeks ago. R50's quarterly MDS, dated 10/22/2015, included severe cognitive impairment, and had a diagnoses of right-sided hemiparesis due to cardio vascular accident (stroke), and required extensive assistance of bed mobility and transfers. R50's care plan, updated 11/2/2015 included interventions to prevent contractures, which directed restorative nursing staff to complete daily hamstring and adductor stretches, and ROM (range of motion) to RUE (right upper extremity). R50's restorative flowsheets identified "Hamstring and Adductor stretches per therapy recommendations as resident tolerates, once per day." Range of motion, "RUE [right upper extremity] to shoulder, elbow and wrist in all planes to reduce contracture per therapy recommendations, one per day." A review of R50's restorative flowsheets from October to December 15, 2015 identified the following rehab was completed: -October 2015 14 of 31 opportunities (no documentation on 17 days) -November 2015 23 of 30 opportunities (no documentation x 2 days, "no rehab" x 6 days) -December 2015 8 of 15 opportunities ("pulled" [no rehab] x 7 days	{2 895}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	R 12/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW L	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 895}	Continued From page 10 During an interview on 12/15/15 at 9:37 a.m.,nursing assistant (NA)-A stated she "continues to be pulled" from restorative to work as a NA on the floor. NA-A said at time she will be pulled to the floor until there is a replacement, and she can then resume the restorative duties. NA-A also said "two additional NAs are trained for restorative," and they are also getting pulled to the floor and they were unable to provide rehab during this time. In follow up interview on 12/16/15, at 12:37 p.m., NA-A reviewed R50's Restorative Flowsheets, and verified the dates marked "Pulled," R50 had not received the daily hamstring, adductor stretches, and ROM services. In December R50 only received 8 of 15 opportunities for rehab. During an interview on 12/16/15 at 1:45 p.m. registered nurse (RN)- B said R50's "exercises and stretches" were done by Rehab only. When interviewed on 12/16/15, at 1:19 p.m. DON stated changes have been made to the restorative program, with four additional staff being trained in. She verified when the NAs are short on the floor, the restorative NA may be pulled to assist in getting residents up for the day, and they return to provide restorative services. DON also stated the RN case managers were responsible to review the flowsheets and progress of residents weekly. The DON was unaware that nursing rehab was getting pulled more in December, and restorative services were not being completed for the residents as directed.	{2 895}		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00314	A. Building B. Wing	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20255** Reg. # **MN Rule 4658.0070** LSC	Correction Completed **11/30/2015**	ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **11/19/2015**	ID Prefix **20302** Reg. # **MN State Statute 144.6503** LSC	Correction Completed **11/18/2015**
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **11/01/2015**	ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	Correction Completed **11/30/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **11/30/2015**
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **11/30/2015**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	Correction Completed **11/30/2015**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **11/30/2015**
ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-I** LSC	Correction Completed **11/30/2015**	ID Prefix **21830** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **11/30/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	12/30/2015	32613	12/16/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/20/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245360	A. Building B. Wing 01 - MAIN BUILDING 01	12/13/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 11/25/2015	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 11/25/2015	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By TL/KJ	Date: 12/30/2015	Signature of Surveyor: 34764	Date: 01/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/16/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: C6FZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00314

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245360**

2.STATE VENDOR OR MEDICAID NO.
(L2) **770057500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE LIVING COMMUNITY OF NEW LONDON**
(L4) **100 GLEN OAKS DRIVE**
(L5) **NEW LONDON, MN** (L6) **56273**

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) **02/01/2011**

6. DATE OF SURVEY **10/20/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds 52 (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mardelle Trettel, HFE NE II 11/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/01/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 9, 2015

Mr. James Ingersoll, Administrator
Benedictine Living Community of New London
100 Glen Oaks Drive
New London, Minnesota 56273

RE: Project Number S5360027

Dear Mr. Ingersoll:

On October 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 20, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5360015.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 29, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 29, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 20, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. In addition to the recertification survey, a complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5360015 was completed and substantiated with deficiencies issued at F157.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157		11/19/15

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

Electronically Signed | 11/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 157	Continued From page 1 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify residents' families in a timely manner for 1 of 1 residents (R2) with an elevated laboratory value that needed physician involvement and for 1 of 1 residents (R55) who was administered another resident's medications in error. Findings include: R2's significant change Minimum Data Set (MDS) dated 9/1/15, identified R2 had severe cognitive impairment, and had long term use of anticoagulant medication (used to thin the blood). R2's physician orders dated 10/14/15, identified R2 was prescribed coumadin, a medication to prevent strokes by thinning the blood which is monitored with a laboratory value called an international normalized ratio (INR).	F 157	A: Families of both residents were notified of the elevated INR and the medication error. Notifications completed. B: We identified that all residents on Coumadin or are involved in a medication error could be affected by this, as the process will be for all residents as stated below. All have had the appropriate notification. C: Notification policy was reviewed and describes the notification to family/MD of an elevated INR (> 0.5 points above resident□s goal range and requiring newly ordered medications). Staff was educated on our updated notification policy and documentation of notification. D: 10% of the resident population□s progress notes will be audited by DON or designee for family notifications weekly x 1 month then Biweekly for 1 month, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING _____ B. WING _____	C 10/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(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 157	Continued From page 2 R2's fax communication from the physician dated 8/5/15, identified R2's INR goal was "2.0 - 3.0", but her most recent value was "7.9", more than twice the INR goal for R2. Further, the physician wrote an order, "Adjust coumadin to: Hold 8/5/15; Vitamin K [medication used to reverse the blood thinning effects from coumadin] 2.5 mg [milligrams] p.o. [by mouth] today." R2's medical record was reviewed, there was no indication R2's family had been notified of R2's elevated INR which required a physician involvement and a medication to correct the adverse effect of the coumadin, with a high INR. During interview on 10/19/15, at 1:59 p.m. registered nurse (RN)-A stated when an INR is "significantly outside" of their established goal range and the resident requires Vitamin K, the family "should be notified." Further, R2's family "should have been notified" since her INR was over 3.5, and nursing staff should be documenting the notification in R2's progress notes. When interviewed on 10/20/15, at 8:35 a.m. RN-C stated the family should be notified of all INR results for residents, not just when they are significantly out of range. R2's family is very involved with her care, and they should have "definitely" been notified of R2's increased INR value which required treatment. A facility Change in a Resident's Condition or Status policy dated 9/2013, identified, "...the Nurse Supervisor/Charge Nurse will notify the resident's family or representative [sponsor] when ... There is a significant change in the resident's	F 157	quarterly throughout the following year with results reported to Quality Council.	

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physical, mental, or psychosocial status."

R55's quarterly Minimum Data Set (MDS) dated 8/19/15, identified R55 had severe cognitive impairment.

During an interview on 10/13/2015, at 10:24 a.m. family member (FM)-A stated she upset regarding not being notified of a medication error involving R55 in a timely manner. R55 was given the wrong medication by staff on 5/2/15, but FM-A was not notified of the error until two days later on 5/4/15 when she had "an incidental meeting" with R55's nurse manager.

R55's nursing progress notes dated 5/2/15 to 5/4/15, identified the following:
> 5/2/15 - "Resident pleasant this shift with no negative behaviors noted. Med error performed by TMA, resident was given [another resident's] 2000 [8 p.m.] medications instead of her own. Passed on to monitor resident throughout the night for any adverse effects to medications. MD faxed. Supervisor notified. No adverse effects noted thus far."
> 5/3/2015 - "Res [resident] has been in a pleasant mood this shift. No SE [side effects] noted from med error from last evening."
> 5/4/2015 - "Res alert this shift w/occ [occasional] muttering noted. Appetite fair, eating 75% [percent] of breakfast, did feed self but needed occ ques [sic] to eat. Fluids enc [encouraged]. No nausea voiced."
> 5/4/2015 - "Drt. [daughter] [of R57] notified of med error over the weekend. She asked for a list of the meds that were given to her incorrectly."
The family was notified 2 days after the incident occurred.

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F 157	Continued From page 4 R55's medical record was reviewed and lacked any evidence FM-A had been notified of the medication error prior to 5/4/15. During an interview on 10/15/2015, at 8:48 a.m. registered nurse (RN)-C stated she had been working when the error was reported on 5/2/15. RN-C notified the supervisor of the error, and faxed the physician to update him, but added she did not notify R55's FM-A about it. RN-C stated she was aware FM-A was "very involved" in R55's care, shrugged her shoulders and stated, "I think [FM-A] should have been notified sooner." When interviewed on 10/16/2015, at 10:09 a.m. the social worker (SW) stated "for any little changes" in regard to R55's care, staff know to give FM-A notification adding FM-A should have been notified of the medication error, "Without question, [FM-A] should have been notified." During an interview on 10/16/2015, at 11:56 a.m. the director of nursing (DON) stated since the error occurred, the facility revised its policy to include "timely notification or update of the [resident's] family." Further, the DON stated FM-A should have been "notified right away" after R55 was given the wrong medications. A facility Monitoring Resident Post Medication Error Involving Administration of Incorrect Medications policy updated 6/1/2015, identified, "All sections of the 'Medication Error Report Form for Resident Given incorrect Medication' must be completed as soon as possible; this includes notification of physician and family."	F 157		
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242		11/30/15

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F 242 SS=D	Continued From page 5 MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to following morning routine preferences for 1 of 1 residents (R24) reviewed for choices. Findings include: R24's annual MDS, dated 7/22/15, indicated R24 had intact cognition, and required extensive assistance from staff to complete his activities of daily living. During an interview on 10/12/15, at 6:15 p.m. R24 stated he wanted to be up in the morning by 6:30 a.m., but for approximately the last two months, that had not been happening. R24 stated, "Today, it was 8:30 before they came in to get me up," adding, "Sometimes I hear them complain that they are short of help." A review of the Glenoaks Care Center-Maple 2 nursing assistant care sheet, undated, included, "Likes to get up at 5:30 a.m." During observation on 10/14/15, at 7:54 a.m. R24 was still in bed. NA-A entered R24's room and	F 242	A: This resident□s preference to get up early is being honored. B: Preferences interviews are being completed with all residents to ensure that care plans reflects individual resident preferences. C: Information re: whether preferences are being honored will be added and reviewed at Resident care conferences and Resident Council. D: 10% of the resident population will be interviewed monthly, specifically regarding rising times, exclusive of activity in Care Conferences and Resident Council. This monitoring will be the responsibility of the DON or designee and results will be reported to the Quality Council.	

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stated he was going to get R24 up. R24 stated, "I should be up by now. I like to be up by at least 6:00 a.m." NA-A did not respond.

During an interview on 10/14/15, at 8:49 a.m., NA-A stated he was "new here", but staff typically get the residents who require assistance with eating up first and get everyone else up later. NA-A stated staff try to get to R24 "as soon as we can." Further, NA-A was unaware of R24's preference to be up early.

When interviewed on 10/20/15, at 10:54 a.m. LPN-C stated R24 liked to be up between 5:30 a.m. and 7:00 a.m., but helping him during those times "depends on what else is going on in the building." Further, LPN-C stated the night shift did not typically help residents with morning cares.

During interview on 10/20/15, at 10:56 a.m. NA-I stated, "[R24] likes to get up at 5:30, but night shift won't do it. They make him wait." Further, NA-I stated R24 complains to her and she has told the nurses, but nothing has changed.

When interviewed on 10/16/15, at 12:02 p.m. the director of nursing (DON) stated there is often not enough staff to get residents up in the morning, but the goals was to "to honor all resident choices."

An undated facility Quality of Life-Self Determination and Participation policy indicated the facility, "Respects and promotes the right of each resident to exercise his or her own autonomy regarding what the resident considers to be important facets of his or her life." Further, the policy identified each resident "shall be

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F 242	Continued From page 7 allowed to choose activities, schedules and health care that are consistent with her or her own interest, assessments and plans of care..."	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to develop the comprehensive care plan based on assessment for 1 of 4 residents (R56) who utilized bilateral quarter side rails. Findings include:	F 279	A: Side rail use was added to the care plan for the identified resident. B: All Side rails assessments were reviewed for completion and cross checked with the care plan on 10/28/15. C: Side rail assessment form was modified to add a check/reminder and added to the temporary or permanent	11/1/15

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F 279	Continued From page 8 R56's initial Minimum Data Set (MDS), dated 9/22/2015, indicated R56 was cognitively intact, required extensive assistance with bed mobility, and activities of daily living. During the initial facility tour on 10/12/2015 at 1:19 p.m., R56 was observed to have bilateral quarter side rails on his bed. During an interview on 10/14/2015 at 1:45 p.m. R56 stated he used the side rails and "it necessary to have rail up" to aid in turning. R56's initial Siderail Assessment completed on 09/08/2015 indicated there was no need for the side rails. The facility Side Rail Assessment form dated 09/29/2015 indicated "Therapy request res[resident] have side rails to assist with sitting up in bed and transfers in out of bed and turning bed. Res is alert and oriented." Review of R56's care plan, last updated on 09/29/2015 did not identify that R56 utilized any side rails for bed mobility, even though R56 assessment indicated he needed them. During interview on 10/19/2015 2:31 p.m. RN-A stated the side rails should have been addressed on the care plan and the nursing assistant care sheets, which was reviewed with RN-A at this time. The side rails were missing on the care plan and the nursing assistant care sheets for R56.	F 279	care plan. D: 10% of residents will be audited for Side rail use on care plan. This will be completed by DON or designee on a monthly basis throughout the following year with results reported to Quality Council.	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		11/30/15

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F 282	Continued From page 9 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff followed the plan of care for 2 of 7 residents (R28 and R53) reviewed for activities of daily living (ADLs), 4 of 4 residents (R17, R24, R3, and R29) reviewed for range of motion (ROM), 3 of 4 residents (R57, R35, R28) reviewed for ambulation; 2 of 3 residents (R14, and R31) at risk for pressure ulcers, and for 1 of 3 residents (R2) reviewed for monitoring skin concerns. Findings include: ADL's R28's 5-day Minimum Data Set (MDS) dated 8/26/15, identified R28 had severe cognitive impairment, and required extensive assistance to complete his ADLs. R28's care plan dated 10/9/15, identified an intervention of, "Ambulate to/from meals DAT [distance as tolerated] as he will allow with ext [extensive] 2A [assist of two]; follow behind w/ [with] w/c [wheelchair]." During observation of morning care on 10/14/15, at 9:20 a.m. R28 was assisted with dressing and toileting by nursing assistant (NA)-C, then seated in his wheelchair using a mechanical lift. R28 started to self propel out of his room into the hallway, when an unidentified staff member approached him and pushed him down to the	F 282	Range Of Motion A: The identified residents are being assisted with ROM per care plan. B: All residents that require ROM Services were reviewed for proper ROM services. C: Additional staff has been crossed trained in rehab/ROM to ensure that residents are getting their ROM program per assessment. RN case managers were educated in their responsibility to monitor these programs. D: Staffing coordinator to ensure that there is a Rehab aide 5 days a week to complete ROM/rehab. programs. DON or designee will audit 10% of documentation for completion of ROM weekly x 4 weeks, monthly x 3 months, then quarterly throughout the following year with results reported to Quality Council. Ambulation A: The identified residents identified are being assisted with ambulation. B: All residents that require staff assist with ambulation were reviewed for proper ambulation services. C: Staff educated to provide ambulation services to those residents who have been assessed for services. Care sheets were updated to include everyone on an ambulation plan and to include staff initials and distance. Nurses/ TMAs educated on	

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F 282	Continued From page 10 breakfast meal in his wheelchair. No offer or attempt to ambulate R28 was provided as directed by the care plan. When interviewed on 10/16/15, at 11:28 a.m. restorative aide (RA)-A stated R28 was able to ambulate well using a walker for short distances, and was supposed to be walked by the nursing assistants to meals as directed by his care plan. R53's quarterly MDS dated 9/16/15, identified R53 had moderate cognitive impairment, required extensive assistance for bed mobility, toilet use, and transferring, and had functional limitations in range of motion (ROM) with bilateral impairment to the lower extremities. R53's care plan dated 9/16/15, identified an intervention of, "Staff offer to walk to and from BR [bathroom] as he is able and in halls per his wishes with walker and w/c [wheelchair] to follow." An undated Glenoaks Care Center-Maple 1 nursing assistant care sheet directed staff to, "Amb [ambulate] to/from meals DAT [distance as tolerated] w/ [with] walker et [and] w/c." During an interview on 10/16/15, at 2:35 p.m., restorative aide (RA)-B stated R53 had a restorative program since 6/17/15 for ambulation. RA-B stated, "Therapy wanted me to walk him. He's supposed to walk every day. Sometimes he doesn't want to walk but will always do his pull ups." RA-B also stated, "I try to walk him every day but I get pulled to work on the floor. With the shortage of staffing, it doesn ' t' get done."	F 282	checking these sheets upon completion of shift. D: DON or designee to audit 10% of the care sheets that ambulation is occurring for all residents on ambulation plan weekly x 3 weeks then monthly throughout the following year with results reported to Quality Council. Pressure ulcer A: B: Facility and contracted staff have been educated re: importance of reporting refusal of care to the nurse, alerting another staff for re-approach, and following care sheets and repositioning and toileting plans. C: Agency staff orientation checklist has been updated to include explanation of the care sheets, repositioning and toileting records, and promptly notifying nurse of refusals of repositioning, toileting, and other assistance. D: DON/Designee to audit 10% of repositioning and toileting plan compliance weekly x 4 weeks, biweekly for a month then quarterly throughout the following year with results reported to Quality Council. Skin Monitoring A: Bruise on identified resident has healed. B: All residents have had a skin audit completed with bath and all skin	

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F 282	Continued From page 11 During an interview on 10/19/15, at 11:59 a.m., registered nurse (RN)-A reviewed the Point of Care documentation in R53's electronic medical record, and stated, "The last time [R53] was walked in his room and in the hallway [by nursing assistants] was on 9/14/15. ROM R17's diagnoses, as identified on the care plan revised 9/2/2015, included cerebrovascular disease, hemiplegia and hemiparesis. The annual MDS, dated 8/24/2015, indicated R17 required extensive assistance with most ADLs, including bed mobility and transfers. The MDS indicated R17 was cognitively intact. R17's care plan, updated 9/2/2015, identified mobility as a care area, and directed a restorative nursing program. R17's program included an "exercise group," " ROM (range of motion)" to upper and lower extremities, and direction to "monitor for change" in ability to participate in group exercises and changes in assist with activities of daily living. In an interview on 10/16/2015 at 9:41 a.m., registered nurse (RN)-A stated the "nurse managers" were in charge of the restorative programs, that they reviewed "their own resident" and "should be monitoring progress, as well if the programs "are getting done or note." RN-A said she "did not know" if the programs were getting done consistently. RN-A stated there was one primary restorative aide, and her back up is leaving the facility, right now have" not found someone who wants to step in." In an interview on 10/16/2015 at 11:32 a.m.,	F 282	conditions have been assessed and addressed. C: Reviewed with Staff the importance of immediately reporting skin changes to nurse. D: Documentation for all residents with wounds, wound forms, and proper wound documentation and interventions will be audited by DON or designee weekly x 4 weeks then biweekly for one month then quarterly throughout the following year with results reported to Quality Council.	

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restorative aide (RA)-B stated she is supposed to see R17 "three times a week" for his restorative program, which included his upper and lower extremities. RA-B acknowledged R17 was not consistently receiving restorative services.

R24's annual Minimum Data Set (MDS) dated 7/22/15, identified R24 had intact cognition, required extensive assistance of two staff for bed mobility and transferring, and had functional limitations in range of motion (ROM) with bilateral impairment to upper and lower extremities.

R24's care plan, dated 10/11/15, identified R24 had impaired functional range of motion with contractures to all extremities related to diagnosis, and included a goal to maintain the ability to bear weight for transfers and to feed himself. R24's care plan included providing massage to neck prior to starting range of motion, passive range of motion (PROM) to left upper extremity, active assistive range of motion (AAROM) to right upper extremity, and bilateral lower extremity exercises with weights, knee extension, and hamstring curls.

R24's Restorative Flowsheets dated 7/1/15-10/20/15, identified R24's restorative program had been documented as completed as follows:

> July 2015 10 of 14 opportunities
> August 2015 6 of 13 opportunities
> September 2015 5 of 13 opportunities
> October 2015 1 of 8 opportunities

During an interview on 10/16/15, at 7:59 a.m., restorative assistant (RA)-A stated R24 was

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scheduled to receive restorative program, three times a week, but this wasn't always getting done. RA-A stated, "We have been getting pulled more and more to work the floor, so we've been getting to this [restorative program] less and less. We try to do the best we can but with staffing, it's been tough. We are pretty short." RA-A stated only two staff were trained to do the restorative program so other staff did not do the program with residents. RA-A stated, "Residents get frustrated when their exercises and walking aren't done," and stated he had reported this to the previous director of nursing (DON).

R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 to have moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff for transfers. The MDS also identified R3 to have bilateral impairment to the lower extremities, with zero days receiving passive ROM.

R3's care plan dated 9/30/15, identified R3 with a goal to maintain ankle ankle and foot passive range of motion (PROM) including dorsiflexion (toes upward), plantarflexion (toes downward) with 15 reps each foot, heel cord stretches (toes upward and hold 30 seconds, with three reps to each foot/ankle), up to three times weekly as he tolerates.

Review of R3's Restorative Flowsheets dated 6/1/15 to 10/20/15, identified R3's received PROM 25 of 65 opportunities during this time frame.

When interviewed on 10/16/15, at 8:07 a.m. restorative aide (RA)-A stated the provided

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restorative services are identified on the Restorative Flowsheet. The restorative programs are not being consistently completed as the restorative aides are pulled to the floor to help with cares due to being short staffed. RA-A is typically scheduled to work on restorative programs four days a week, but is consistently pulled away from them three of the four days. The nursing assistants (NA) are not trained, nor do they complete restorative programs. Further, RA-A stated these concerns had been reported to the former director of nursing (DON).

R29's quarterly Minimum Data Set (MDS) dated 8/29/15, identified R29 had long and short term memory problems, was totally dependent on staff for her ADLs, and had limitations in her ROM on both sides of her body.

R29's care plan dated 9/4/15, identified R29 was "at moderate risk" of contractures, and had "limited" ROM to her bilateral shoulders. Further, the care plan identified an intervention of, "PROM up to 3 X [times] weekly per therapy recommendations."

Review of the Restorative Flowsheet Records from 8/2015 to 10/15/15 identified that PROM was to be offered three times a week. The Restorative Flowsheet Records identified R29's received the following PROM:
> July 2015 10 of 13 opportunities
> August 2015 5 of 13 opportunities
> September 2015 2 of 13 opportunities
> October 2015 2 of 7 opportunities

When interviewed on 10/16/15, at 7:59 a.m., restorative aide (RA)-A stated he had been getting pulled to the floor to do cares instead of

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restorative programs, so the restorative programs had been getting completed "less and less." Further, only two staff were trained to complete restorative programs.

AMBULATION

R57's diagnoses, as identified on physician's orders dated 9/16/2015, included hemiplegia and hemiparesis. The quarterly MDS, dated 9/10/2015, indicated R57 required extensive assistance with transferring, and activities of daily living. The MDS also indicated he had intact cognition.

During observation on 10/14/2015 at 7:45 a.m. nursing assistant (NA)-B assisted R57 with morning cares. R57 used a hemi walker (an assistive walking device) to move from the bed and transfer into his wheel chair, while NA-B used a gait belt to assist R57.

In an interview on 10/15/15 at 2:15 p.m., R57 stated he participates in a walking program, but lately he was only getting assistance with walking, "once a day," with two nursing assistants. R57 stated the walks "do not happen on the weekend."

A Therapy to Restorative Nursing Communication Form, dated 6/30/2015, indicated R57 was to ambulate with (R57) daily in hallway, using assistance of 1 with gait belt, and 1 to push the wheel chair behind. Walk the length of handrail, 1-3 times per day.

A review of R57's Restorative Flowsheets from

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7/1/2015 to 10/10/2015 indicated R57 had ambulated 39 out of 102 opportunities.

In an interview on 10/16/2015 at 8:18 a.m., restorative aide (RA)-A stated that R57 had a restorative ambulation program to walk in the hallway, and also that R57 "was pretty persistent about getting his walking done." RA-A stated he "was getting pulled" to work on the floor, and the restorative programs were often missed and not completed on the weekends.

R35's diagnoses, as identified on the care plan, updated 10/13/2015, included Parkinson's disease, weakness, and history of falling. The quarterly Minimum Data Set (MDS), dated 6/25/2015, indicated R35 required extensive assistance with transferring, bathing and most activities of daily living. The MDS also indicated R35 had intact cognition.

R35's care plan, updated 10/13/2015, identified mobility as a care area, and directed staff to "walk to and from meals with FWW &1A (4 wheeled walker and assist of 1), pull w/c (wheel chair) behind, distance as tolerated.

During observation on 10/19/2015 at 12:05 p.m., R35 was in her wheel prior to the start of lunch, and NA-G pushed R35 from her room into the dining area. NA-G did not offer to ambulate R35.

In an interview, on 10/19/2015 at 12:08 p.m., NA-G said she did not know R35 was on a walking program.

During an interview on 10/16/2015 at 11:32 a.m.,

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rehabilitation aide (RA)-B stated R35 "had no formal restorative program," but that she was to be walked from her room to the dining room, as much as she could. RA-B stated R35 was not always a willing participant, and needed encouragement, but it was important for her to keep walking. RA-B was not sure where R35's walking was documented or if the program was consistently implemented for R35.

In an interview on 10/19/2015 at 3:01 p.m., registered nurse (RN)-B stated she did not know whether R35's walking program "was documented anywhere." RN-B also stated her walking program "is on the CNA care sheet", and that the nursing assistants "are supposed to document." RN-B added that "right now" the walking and restorative programs were not getting monitored, and "probably were not recorded."

R28's 5-day MDS dated 8/26/15, indicated R28 had severe cognitive impairment, and required extensive assistance, was unable to walk in the room or corridor, used a wheelchair for mobility and had no episodes of rejecting cares.

R28's care plan dated 10/9/15, directed staff to ambulate R28 to and from meals, as tolerated with extensive assistance.

During observation of personal cares on 10/14/15, at 9:20 a.m. NA-C assisted R28 to transfer into his wheelchair. R28 then propelled himself in his wheelchair with his feet into the hallway. An unidentified staff walking by R28, offered to push him to the dining room for

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breakfast, which he accepted. Staff did not offer R28 to walk to his meal, as identified in his care plan.

During interview on 10/16/15, at 11:28 a.m. restorative aide (RA)-A stated R28 was not on the restorative program, but staff were directed to walk him as directed on the care plan. RA-A stated R28 walked well with a walker for short distances.

During interview on 10/16/15, at 12:01 p.m. NA-G stated R28 does not walk, and she was not aware nursing was supposed to be walking R28.

PRESSURE ULCER

R14's annual Minimum Data Set (MDS) dated 9/8/15, identified R14 to be cognitively intact, require extensive assistance with bed mobility, transfers, toileting and was frequently incontinence of urine.

R14's care plan dated 9/18/15, identified a risk for skin breakdown related to pressure, and was incontinence of urine. The care plan directed staff to turn and reposition (R14) every two hour, and to provide toileting on rising, every 1.5 hours when awake, every two hours at night, and as needed.

On 10/13/15, at 3:42 p.m. R14 observed lying in bed, on her back. R14 stated she was not receiving the help for repositioning, and had an open area on her buttocks. R14 stated the wound nurse ordered turning every 1.5 hours, but

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she was lucky to get help once during the day and once at night.

During continuous observation on 10/14/15, from 7:01 a.m. to 9:44 a.m. R14 was laying in bed in her room. R14 was not offered or provided with any toileting or incontinence cares for 2 hours and 43 minutes. When notified of the lack of toileting or incontinence care for R14 on 10/14/15, at 9:40 a.m. licensed practical nurse (LPN)-C stated R14 should have been assisted with toileting every two hours.

When interviewed on 10/14/15, at 9:40 a.m. LPN-C stated R14 is to be turned, repositioned, and offered toileting every two hours, and it would not be acceptable to go from 7:01 a.m. to current time (9:40 a.m.) with no one offering (R14) to be toileted or repositioned.

On 10/14/15, at 9:44 a.m. LPN-C and NA-D entered R14's room, assisted R14 to turn to the right and placed pillow under left side. R14 was offered to assist in using the bathroom but R14 refused.

When interviewed on 10/14/15, at 1:02 p.m. NA-C stated R14 would be repositioned if the bedpan was used, and believed repositioning should be offered every two hours.

When interviewed on 10/14/15, at 1:46 p.m. RN-B stated R14 was frequently incontinent of bowel and bladder, and is to be offered toileting and repositioning. RN-B stated it would not be acceptable to go two hours and 45 minutes without offering toileting or repositioning, and it should be offered every hour.

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R31's quarterly MDS dated 9/9/15, indicated severe cognitive impairment required extensive assistance for bed mobility and was at risk for developing a pressure ulcer.

R31's care plan dated 9/21/15, indicated R31 to be at risk for skin impairment with interventions including alternating air mattress on bed, cushion in wheelchair, heel boots on when in bed, and elevate feet on a pillow when in bed or recliner.

During observation of morning care on 10/15/15, at 6:28 a.m. R31 did not have a pillow under R3's feet. On 10/16/15, at 9:54 a.m. R31 was in bed, with no pillow underneath the feet.

When interviewed on 10/15/15, at 11:05 a.m. RN-C stated R31 was to have a pillow under the feet when in bed to assist in preventing pressure ulcers.

When interviewed on 10/16/15, at 9:58 a.m. NA-D and NA-C was unaware R31 should have a pillow underneath the feet when in bed.

When interviewed on 10/16/15, at 10:02 a.m. RN-C stated (R31) was to have a pillow placed under the feet when in bed.

When interviewed on 10/20/15, at 9:34 a.m. RN-C stated staff were informed of the cares required on the care sheets, and in the communication book for R31 to have pillows under his feet.

When interviewed on 10/20/15, at 9:40 a.m. NA-C stated no pillow had been placed under

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R31's feet when he was assisted to bed after breakfast, and indicated she was not aware this was required.

SKIN MONITORING

R2's diagnoses, as identified on the significant change Minimum Data Set (MDS), dated 9/1/15, included long term (current) use of anticoagulants, and was severely cognitively impaired.

R2's care plan, dated 9/14/15, identified skin as a focus and included, "At risk for bruising r/t [related to] Coumadin usage. Easily bruises and skin is thin and fragile and gets skin tears easily r/t bumping into things with her w/c [wheelchair]." The care plan directed staff to, "Monitor skin w [with]/daily cares and wkly [weekly] bath. Monitor for bruising r/t Coumadin use. Monitor for suspicious lesions and refer to MD PRN" [as needed].

On 10/12/15, at 7:04 a.m. R2 was observed to have a bruise on the top of her left hand.

On 10/14/15, at 7:55 a.m. R2 was observed in the dining room. The top of R2's left hand was black and blue in color with a bruise extending from her knuckles to the wrist, approximately 2.5 inches x 5 inches.

During an interview on 10/14/15, at 8:26 a.m. R2 stated she was not sure how she got the bruise on the top of her left hand. She may have "bumped into something." R2 knew she was on a blood thinner, and said this was why she bruised "easily."

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When interviewed on 10/14/15, at 9:15 a.m. nursing assistant (NA-G) stated she saw the bruise on R2's hand on the morning of 10/12/15 when she came to work. NA-G further stated, "I did not tell anyone" and "assumed" R2's bruise was already reported.

During interview on 10/14/15, at 9:17 a.m. NA-H stated she saw the bruise on R2's hand at 6:00 a.m. on 10/12/15, also when NA-H came to work. NA-H said she asked R2 what the bruise was from, but R2 did not recall where the bruise came from. NA-H also said, "I did not report the bruise to anyone."

When interviewed on 10/14/15, at 9:28 a.m. licensed practical nurse (LPN)-B stated, she was "not aware" R2 had a bruise on the top of her left hand. LPN-B also stated she took care of R2 "yesterday" (10/13/15), too, but did not see the bruise on top of R2's hand. In addition, LPN-B also said "no one had reported" the bruise to me and the "should have." LPN-B then stated she would measure the bruise and place on the treatment sheet to monitor it daily.

A progress note dated 10/14/15, at 12:59 p.m. indicated R2's bruise was, "A 6 cm x 13 cm bruise was noted on top of Lt [left] hand on the weekend, when asked what had happened stated, 'I bump my hand all the time on the faucet or the EZ stand, its nothing'. Bruise is starting to turn yellow around the edges. Will monitor q [every] day."

Review of the Facility policies titled Care Planning - Interdisciplinary Team revision date 9/13, and

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F 282	Continued From page 23 Care Plans - Comprehensive revision date 9/10, did not address implementation of the care plan.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor bruising for 1 of 1 residents (R2) who was identified at risk of bleeding, due to her medication regime. Findings include: R2's significant change Minimum Data Set (MDS) dated 9/1/15, identified R2 had severe cognitive impairment, and had long term use of anticoagulant medication (used to thin the blood). R2's care plan dated 9/14/15, identified R2 was, "At risk for bruising r/t [related to] Coumadin usage. Easily bruises and skin is thin and fragile and gets skin tears easily r/t bumping into things with her w/c [wheelchair]." The care plan directed staff to, "Monitor skin w [with]/daily cares and wkly [weekly] bath. Monitor for bruising r/t Coumadin use. Monitor for suspicious lesions and refer to MD PRN" [as needed].	F 309	A: Bruise on identified resident was healed on 11/4/15. B: All residents have had a skin audit completed with bath and all skin conditions have been assessed and addressed. C: It was reviewed with nursing to follow the policies and procedures r/t skin impairment. Policies and procedures r/t skin issues were reviewed and implemented. It was reviewed with CNAs and bath aides on immediate notification of nurse when finding a skin issue. Reviewed with CNAs the information to report to a nurse. D: Documentation for all residents with wounds, wound forms, and proper wound documentation and interventions will be audited by DON or designee weekly x 4 weeks then biweekly for one month then monthly throughout the following year with results reported to Quality Council.	11/30/15

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On 10/14/15, at 7:55 a.m. R2 was observed in the dining room. The top of R2's left hand was black and blue in color. The bruising extended from her knuckles to the wrist, approximately 2.5 inches x 5 inches.

During an interview on 10/14/15, at 8:26 a.m. R2 stated she was not sure how she got the bruise on the top of her left hand. She stated she may have "bumped into something," was on a blood thinner, and this was why she bruised "easily."

Review of the medical record identified R2's physician orders dated 10/14/15, identified R2 was prescribed coumadin, a medication to prevent strokes by thinning the blood which is monitored with a laboratory value called an international normalized ratio (INR).

R2's fax communication from the physician dated 8/5/15, identified R2's INR goal was "2.0 - 3.0", but her most recent value was "7.9", more than twice the INR goal for R2. Further, the physician wrote an order, "Adjust coumadin to: Hold 8/5/15; Vitamin K [medication used to reverse the blood thinning effects from coumadin] 2.5 mg [milligrams] p.o. [by mouth] today."

When interviewed on 10/14/15, at 9:15 a.m. nursing assistant (NA-G) stated she saw the bruise on R2's hand on the morning of 10/12/15 (2 days ago) when she came to work. NA-G further stated, "I did not tell anyone" and "assumed" R2's bruise was already reported and being monitored.

During interview on 10/14/15, at 9:17 a.m. NA-H stated she first saw the bruise on R2's hand at

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6:00 a.m. on 10/12/15. R2 did not recall where the bruise came from, nor did NA-H report it to the nurses, "I did not report the bruise to anyone."

When interviewed on 10/14/15, at 9:28 a.m. licensed practical nurse (LPN)-B stated, she was "not aware" R2 had a bruise on the top of her left hand. LPN-B took care of R2 "yesterday" (10/13/15), but did not see the bruise on top of R2's hand. LPN-B stated "no one had reported" the bruise to her, and if any of the nursing assistants noted the bruise, they "should have" reported the bruise. Further, LPN-B stated she would begin monitoring the bruise that day, on 10/14/15.

R2's medical record identified a physician communication fax dated 10/14/15, identified R2's INR (international normalized ratio) goal range was 2.0 to 3.0; and her INR was 5.7 on 10/14/15. The physician provided orders to hold all doses of coumadin for R2 and recheck her INR on 10/16/15.

During interview on 10/16/15, at 7:56 a.m. registered nurse (RN)-A said nursing assistants "are expected" to report new bruises to the nurse on duty. All NA's receive training (Expectations for Resident Cares) with orientation which tells them to report bruising and changes in skin condition, "My expectation is that nursing assistants would report all bruises when first observed." RN-A stated the bruising should have been monitored, and if there is a concern we need to contact the physician to get an INR level promptly to ensure the coumadin was in the therapeutic levels of (2.0 to 3.0) for this resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 26 Although R2 was on coumadin, and had a history of high INR levels, the facility was not consistently monitoring R2's bruising to ensure her INR levels remained in therapeutic range for R2. An undated Expectations for Resident Cares: Nursing Assistant Care Delivery Practice Demonstrated Appropriate Care training document identified, "Changes in resident condition are reported to licensed nurse, including but not limed to ... Changes in skin condition."	F 309		
F 311 SS=E	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide and consistently implement ambulation services to improve and/or maintain residents' ambulation abilities for 4 of 5 residents (R57, R35, R28 and R53) in the sample reviewed for restorative nursing services. Findings include: R57's diagnoses, as identified on physician's orders dated 9/16/2015, included intracerebral hemorrhage, hemiplegia and hemiparesis. The quarterly MDS, dated 9/10/2015, indicated R57 required extensive assistance with transferring, bathing and most activities of daily living. The	F 311	A: the identified residents are being assisted with ambulation. B: All residents that require staff assist with ambulation were reviewed for proper ambulation services. C: Staff educated to provide ambulation services to those residents who have been assessed for services. Care sheets were updated to include everyone on an ambulation plan and to include staff initials and distance. Nurses/ TMAs educated on checking these sheets upon completion of shift. D: DON or designee to audit 10% of the care sheets that ambulation is occurring for all residents on ambulation plan weekly x 3 weeks then monthly	11/30/15

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F 311	Continued From page 27 MDS also indicated he had intact cognition. A care area assessment (CAA) for functional status/rehabilitation potential, dated 6/15/2015, indicated R57 required assistance with all ADLs, and was walking with therapy. During observation on 10/14/2015 at 7:45 a.m. nursing assistant (NA)-B assisted R57 with morning cares. R57 used a hemi walker (an assistive walking device) to move from the bed and transfer into his wheel chair, while NA-B used a gait belt to assist R57. In an interview on 10/15/15 at 2:15 p.m., R57 stated he participates in a walking program, but lately he was only getting assistance with walking, "once a day," with two nursing assistants. R57 stated the walks "do not happen on the weekend." A Therapy to Restorative Nursing Communication Form, dated 6/30/2015, indicated R57 was to ambulate with (R57) daily in hallway, using assistance of 1 with gait belt, and 1 to push the wheel chair behind. Walk the length of handrail, 1-3 times per day. A PT (physical therapy) Therapist Progress and Discharge summary, dated 8/19/2015, indicated R57 had received skilled services including gait training and neuromuscular re-education, which improved R57's abilities "with bed mobility, transfer and ambulation." The discharge plan included "continue walking with restorative nursing and perform LE (lower extremity) strength maintenance program. A review of R57's Restorative Flowsheets from 7/1/2015 to 10/10/2015 indicated R57 had	F 311	throughout the following year with results reported to Quality Council.	

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F 311	Continued From page 28 documented ambulation services: July 22 of 31 opportunities (no refusals documented) August 12 of 31 opportunities September 3 of 30 opportunities October 2 of 10 opportunities In an interview on 10/16/2015 at 8:18 a.m., restorative aide (RA)-A stated that R57 had a restorative ambulation program to walk in the hallway, and also that R57 "was pretty persistent about getting his walking done." RA-A said R57's program was missed, but said it was completed more than was documented. RA-A stated R57 had not declined in his ability, even though some walking days were missed. RA-A stated more and more he "was getting pulled" to work on the floor, it seemed "about 50% of the time." RA-A stated lately it was "pretty frustrating" not getting the residents' programs done, even though he was scheduled for rehab more frequently. RA-A said the restorative programs were often missed and not completed on the weekends. RA-A stated if he had questions about a residents restorative program, he would ask the physical or occupational therapy department but was not sure who was in charge of the restorative program at the facility. In an interview on 10/16/2015 at 9:41 a.m., registered nurse (RN)-A stated the "nurse managers" were in charge of the restorative programs, that they reviewed "their own resident" and "should be monitoring progress, as well if the programs "are getting done or note." RN-A said she "did not know" if the programs were getting done consistently. RN-A stated there was one primary restorative aide, and her back up is leaving the facility, right now have" not found	F 311		

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someone who wants to step in."

R35's diagnoses, as identified on the care plan, updated 10/13/2015, included Parkinson's disease, weakness, and history of falling. The quarterly Minimum Data Set (MDS), dated 6/25/2015, indicated R35 required extensive assistance with transferring, and activities of daily living. The MDS also indicated R35 had intact cognition. The CAA for ADLs Functional Status/Rehabilitation Potential, dated 3/25/2015, indicated she had an acute decline in ADLs and mobility and increased weakness related to a recent GI blood. The CAA also indicated R35 had Parkinson's, which impacted her independence and ADLs.

A PT -Therapist Progress & Discharge summary, dated 5/17/2015, indicated R35 received physical therapy from 3/19/2015 to 5/17/2015. The report indicated R57 "...has shown gains in strength, activity tolerance and neuromuscular function which allowed for increased distances walking and improved transfers and ambulation." The discharge plan included "Recommendation discussed with patient and/or caregivers include Restorative Nursing program."

A review of Glen Oaks Care Center - Oak nursing assistant care sheet, printed 10/16/2015, directed "walk [R57] to and from DR (dining room) TID (three times a day) as tolerated."

In an interview on 10/16/2015 at 11:32 a.m., RA-B stated R35 "had no formal restorative program," but that she was to be walked from her room to the dining room, as much as she could. RA-B stated R35 was not always a willing participant,

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and needed encouragement, but that is was important for her to keep walking. RA-B was not sure where R35's walking was documented.

In an interview on 10/16/2015 at 9:33 a.m., R35 stated during cares she "walk to the bathroom, I did that yesterday." R35 also said she "sometimes refuses to walk," but the staff has not asked me to walk "for a long time." R35 also said she walked more a couple months ago, "in summer they would take me," but not of late. R35 also said her feet hurt when she walked, "and my balance is off."

During observation on 10/19/2015 at 12:05 p.m., R35 was seated in her wheel chair, prior to the start of lunch, and NA-G pushed R35 from her room into the dining area. NA-G did not offer to ambulate R35.

In an interview, on 10/19/2015 at 12:08 p.m., NA-G said she "did not know" R35 was on a walking program.

In an interview on 10/19/2015 at 3:08 p.m., NA-N stated R57 "has not walked down the the dining room this past week." NA-N stated during his afternoon shift, he has asked R57 to ambulate, and the past couple of times "she has refused," and instead would rather be pushed in her wheel chair. NA-N stated he was not aware if R57 was on a walking program.

In an interview on 10/19/2015 at 3:01 p.m., registered nurse (RN)-B stated she did not know whether R35's walking program "was documented anywhere." RN-B said since most recent care conference, R35 expressed her legs were hurting more, and was refusing more to

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walk. RN-B also stated her walking program "is on the CNA care sheet", and that the nursing assistants "are supposed to document." RN-B added that "right now" the walking and restorative programs were not getting monitored, and "probably were not recorded."

In an interview on 10/19/2015 at 3:12 p.m., NA-O stated R35 "was able to walk, if people would take her." NA-O stated the nursing assistants used to record ambulation in a book, but now recorded distances "on the aide sheets." NA-O said the sheets were to be turned in every day, "but I have not seen them get turned in lately." NA-O said she "did not know" if all the aides were aware of this. NA-O said the facility had this concern before, where residents did not get walked, or their restorative programs, then staff would get reminders, "and it improved for a while, then kinda goes by the wayside." NA-O also said [walking] is the care sheets, "and it would be expected that we do it." NA-O also said she thought the real issue "was time, and not enough help."

In an interview on 10/20/2015 at 9:18 a.m., the physical therapist (PT) stated the facility "should have a stronger follow up program after residents are discharged from therapy. The PT said in the past, "we had a weekly meeting with the RN in charge of the resident and the rehab aid" and "every resident would be discussed" at least monthly, and it "did not matter" whether a resident was getting therapy or was on a range of motion or walking program." The PT said it was a way for us to "catch things" before a resident lost functionality. The PT said restorative programs "were not" consistently completed and it was difficult to get and retain qualified staff, but "we

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still have to take care of the residents."

R28's 5-day MDS dated 8/26/15, indicated R28 had severe cognitive impairment, and required extensive assistance of two staff for transferring and toileting. The MDS further indicated R28 had no episodes of rejecting cares, did not walk in the room or corridor during the assessment period, and used a wheelchair for mobility.

R28's care plan dated 10/9/15, directed staff to ambulate R28 to and from meals, as tolerated with extensive assistance.

A review of R28's Physical Therapy Plan of Care dated 8/21/15, identified a long term goal which included, "[R28] will ambulate daily with nursing staff 100 feet safely with front wheeled walker and contact guard assist on even surfaces."

During observation of personal cares on 10/14/15, at 9:20 a.m. NA-C assisted R28 using a mechanical lift to transfer into his wheelchair. R28 then propelled himself in his wheelchair with his feet into the hallway. An unidentified staff walking by R28's room, offered to push him to the dining room for breakfast, which he accepted.

During interview on 10/16/15, at 11:28 a.m. restorative aide (RA)-A stated R28 was not on the restorative program, but staff were directed to walk him as directed on the care plan. RA-A stated R28 walked well with a walker for short distances.

During interview on 10/16/15, at 11:38 a.m. health information coordinator (HIC)-A stated R28 had been admitted to the facility three times in the

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past, and would transfer himself into the recliner. HIC-A stated R28 does not ambulate as much now because he propels himself in the wheelchair with his feet.

During interview on 10/16/15, at 12:01 p.m. NA-G stated R28 does not walk, and she was not aware nursing was supposed to be walking R28.

During interview on 10/16/15, at 12:14 p.m. HIC-A stated the former RN case manager placed R28's restorative nursing on hold after his most recent hospitalization on 8/17/15, because he was working with therapy at the time, and was waiting to see what therapy recommended. HIC-A stated she was not aware of the new Physical Therapy Plan of Care dated 8/21/15, which directed staff to ambulate the resident daily with nursing staff 100 feet.

During interview on 10/16/15, at 1:14 p.m. PT-A stated physical therapy made a recommendation to nursing on 8/21/15, after R28's last hospital return, to walk with staff daily 100 feet. PT-A was unable to find any communication of this direction to nursing, and stated it must had gotten missed.

On 10/16/15, at approximate 1:20 p.m. PT-A assisted R28 to walk approximately 90 feet. PT-A stated R28 did not have a decline in ambulation, and would ensure nursing was aware of the recommended to walk R28 daily to maintain current ambulation ability.

R53's quarterly MDS dated 9/16/15, identified R53 had moderate cognitive impairment, required extensive assistance of one for transferring, and

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had walked once or twice with extensive assistance in his room and corridor. In addition, the MDS identified R53 had no displays of behavior or rejection of cares.

During an observation on 10/13/15, at 3:47 p.m., R53 was lying in bed, on the left side, with his blankets over head. When approached, R53 rolled slightly onto his back, with both knees bent.

R53's Care Area Assessment, dated 6/11/15, identified, "Res [resident] at risk r/t [related to] diagnoses: hemiparesis (LEFT), TIA, DM, PVD, and HX [history] of hamstring contractures. Requires ext [extensive] assist with bed mobility, transfers, ambulation, locomotion...Impaired functional ROM to (B) LE [bilateral lower extremities]. He does have (B) hamstring contractures. Currently working with OT (occupational therapy) to regain some ability to ambulate and stand better."

A review of a progress note, dated 6/17/15, identified R53 had been discharged from therapy on 6/16/15, and, "Therapy recommends restorative. Recommendations include ambulate to meals as tolerated to stretch hamstrings with feet and lower legs on bolster for several minutes to facilitate mobility. Resident is on the list to ambulate to meals with staff. Will place on ambulation program with restorative as well and sit to stand at bar to stretch hamstrings d/t [due to] contractures."

R53's care plan, dated 9/16/15, included, "Staff offer to walk to and from BR [bathroom] as he is able and in halls per his wishes with walker and w/c [wheelchair] to follow."

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A review of the Glenoaks Care Center-Maple 1 nursing assistant care sheet, undated, directed staff to, "Amb [ambulate] to/from meals DAT [distance as tolerated] w/ [with] walker et [and] w/c."

Review of R53's Therapy to Restorative Nursing Communication Form, dated 6/16/15, indicated R53's goals to work towards, were transfers, standing, and mobility, and included, "Ambulate to meals as tolerated. Can stretch hamstrings w/ feet and lower legs on bolster for several minutes to facilitate mobility...Encourage Pt [patient] to participate as much as possible."

Review of the Restorative Flowsheets from 6/17/15 -10/19/15, indicated the ambulation program had been completed as follows:

June 2015 7 of 13 opportunities
July 2015 23 of 31 opportunities with 2 refusals
August 2015 10 of 31 opportunities with 3 refusals
September 2015 5 of 30 opportunities with 1 refusal
October 2015 0 of 19 opportunities with 2 refusals

During an interview on 10/16/15, at 2:11 p.m., R53's family member (FM)-A stated, "I'm concerned because there was a Hoyer [mechanical lift] sling in [R53's] recliner today. He's supposed to be walked. They are so understaffed." FM-A stated R53 had potential to become more contractured if staff weren't walking and stretching his legs.

During an interview on 10/16/15, at 2:35 p.m.,

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restorative aide (RA)-B stated R53 had a restorative program since 6/17/15 for ambulation. RA-B stated, "Therapy wanted me to walk him. He's supposed to walk every day. Sometimes he doesn't want to walk but will always do his pull ups." RA-B also stated, "I try to walk him every day but I get pulled to work on the floor. With the shortage of staffing, it doesn't get done."

During an interview on 10/16/15, at 3:05 p.m., certified occupational therapy assistant (COTA) stated, "When we discharge a resident from therapy and recommend restorative nursing, that becomes a nursing program." She would expect the nursing staff to monitor residents receiving restorative program and discuss concerns at the Interdisciplinary Team (IDT) meetings, which the physical therapist and COTA attended.

During an interview on 10/19/15, at 11:59 a.m., registered nurse (RN)-A reviewed the Point of Care documentation in R53's electronic medical record, and stated, "The last time [R53] was walked in his room and in the hallway [by nursing assistants] was on 9/14/15."

Facility policy titled Range of Motion Exercises revision date 10/10, identified the following should be recorded in the resident's medical record:
- the date and time that the exercises were performed
- the name and title of the individual(s) who performed the procedure
- the type of range of motion exercise given
- whether the exercise was active or passive
- how long the exercise was conducted

Reporting
- notify the supervisor if the resident refuses the

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F 311	Continued From page 37 exercises - any problems or complaints made by the resident related to the procedure - any changes in the resident's ability to participate in the procedure - if the resident refused the treatment, the reason(s) why and the intervention taken - report other information in accordance with facility policy and professional standards of practice	F 311		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide bathing assistance for 6 of 7 residents (R17, R35, R57, R33, R47 and R24), who were dependent upon staff for bathing. Findings include: BATHING: R17's annual Minimum Data Set (MDS) dated 8/24/2015, indicated R17 had intact cognition, required extensive assistance to complete his activities of daily living (ADLs), including bathing. During observation on 10/14/2014, at 8:41 a.m.	F 312	A, B: Bathing of all residents is being completed per resident preferences. C: Bath schedule was modified to include documentation that baths are being completed. Staffing hours have been adjusted to ensure that all baths are being completed per resident preference. Additional staff has been cross trained in baths to ensure bathing schedules are met. D: The bath schedule will be monitored weekly for bath completion by DON or Designee x 6 weeks or until sustained compliance is achieved, then monthly x two months, then quarterly throughout the following year with results reported to	11/30/15

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F 312	Continued From page 38 R17 was seated in a wheel chair in the main dining room, wearing glasses, his hair was combed, but was unshaven. In an interview on 10/14/2015, at 1:44 p.m. R17 stated "you just don't get baths regularly like you're supposed to," adding "the people don't show up for work." R17 was supposed to have a bath "yesterday" and was hoping to get one today, "but it didn't happen", and this seems to happen "often, too often." R17 stated he was not shaved because shaving goes along with the bath, adding, "It bothers me more that I didn't get a bath." Further, R17 stated he doubted he could get a bath tomorrow, "but I bet I'll get a bath first on Friday, day after tomorrow. I may not get shaved until Friday." A facility Bath Schedule AM dated 9/21/2015, indicated R17 had his whirlpool baths scheduled on Tuesdays and Fridays. R17's bathing documentation from October 1 - 16, 2015 indicated he had received only one bath during that time, on 10/6/15. The documentation did not indicate if R17 had refused any bathing opportunities. Review of the facility Grievance Report dated 10/06/15, indicated R17 missed his bath on 10/6/15, and on 10/02/15. The report indicated R17 was provided a bath on 10/6/15, after the grievance was filed. In interview on 10/16/2015 at 10:34 a.m., RN-C stated she monitors resident bathing completion "by way of the aide documentation." RN-C said that "every once in a while" the bath aide gets pulled to the floor "when we are short," but added,	F 312	Quality Council.	

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"I honestly don't know how often that happens." Further, RN-C stated she "could not state" R17 had a more recent bath since 10/6.

R35's quarterly MDS dated 6/25/2015, indicated she had intact cognition, and required extensive assistance with transferring, bathing and most activities of daily living.

During an interview on 10/14/2015, at 9:41 a.m. R35 stated that bathing "doesn't happen." She had staff tell her "they are going to do it," then "there is no one to do it." R35 said she was suppose to be bathed twice a week, "and I get bathed once a week." R35 stated last week it was "eight days" between baths adding, "They keep postponing my bath."

A facility Resident Choices for Bathing document dated 3/18/2015, indicated R35 wanted two baths a week and preferred the time of "morning, after breakfast Tuesday & Thursday." The form was signed by R35.

A facility Bath Schedule AM dated 9/21/2015, indicated R35 had whirlpool bath scheduled on Tuesdays and Fridays.

In an interview on 10/16/2015, at 11:41 a.m. registered nurse (RN)-C stated the facility tries to follow "the bath preference sheet, including frequency." RN-C said "I do know we have been behind" in getting residents their bath.

R57's quarterly MDS, dated 9/10/2015, indicated R57 had intact cognition, and required extensive assistance with transferring, bathing and most

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activities of daily living.

During observation on 10/14/2015, at 8:10 a.m. nursing assistant (NA)-C was assisting R57 with morning cares, when R57 asked, "When am I going to get my shower? Is there someone in there right now?" NA-C told R57 the shower room was busy, and then assisted R57 with a transfer into his wheel chair. At 8:17 a.m., NA-C told R57 he would get a shower later this morning, before breakfast.

In an interview on 10/14/2015 at 8:30 a.m., NA-A stated R57 did not receive a bath from her this morning. NA-A said she did not know when he was last bathed.

A facility Resident Choices for Bathing document dated 3/12/2015, indicated R57 wanted two baths a week, on any day, and had no preferred time. The form was signed, 3/12/2015, by a family member.

In an interview on 10/15/2015 at 2:12 p.m., R57 said "that was the first shower I got this week, on Wednesday morning." R57 said he was supposed to be bathed Monday, Wednesday and Friday, and he "did not have" a bath on Monday. R57 said he could not remember when, but he has gone "more than one week" between baths. R57 said of all the things that go on here, "bath days are very important."

R33's quarterly MDS, dated 7/16/2015, indicated R33 had moderate cognitive impairment, and required extensive assistance with her ADLs, including bathing.

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In an interview on 10/19/2015, at 2:28 p.m. R33 stated she would liked to be bathed "more than once a week," but she has "never been bathed" more than once a week. R33 stated staff don't have a whole lot of time, and feels the interaction is always "Hurry up, hurry up, let's get it done," when assisting with cares.

A facility Resident Choices for Bathing document dated 2/11/2015, indicated R33 wanted two baths a week, one on Tuesday, and was signed by R33.

A review of R33's bathing documentation from 8/1/2015 to 10/16/2015 indicated she was bathed on the following dates: 8/4, 8/11, 8/18, 8/25, 9/1, 9/8, 9/15, 9/23 and 10/6. The documentation did not indicate if R33 had refused any bathing opportunities.

In an interview on 10/14/2015 at NA-I stated she did not know how often R33 was to be bathed, or if she got more than one bath every week as identified in the record.

R47's quarterly MDS dated 9/10/15, indicated R47 had moderate cognitive impairment, and required physical assistance with bathing.

During an interview on 10/14/15, at 7:10 a.m. R47 stated his bath days are on Mondays and Fridays. He further states he "hasn't had a bath in quite a while." R47 said "I know it has been several days" since my last bath.

A facility Bath Schedule AM document dated 9/21/15, indicated R47 had whirlpool baths scheduled on Monday and Fridays.

A review of R47's bathing documentation from

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October 1 - 16, 2015 indicated R47 had received only two baths during that time, on 10/9/15 and 10/14/15. The documentation did not indicate if R47 had refused any bathing opportunities.

In an interview on 10/14/15, at 7:16 a.m. nursing assistant (NA)-D stated R47's bath days are on Monday and Fridays. NA-D further stated R47's last bath was Friday (October 9, 2015). Further, NA-D stated R47 did not get his bath on Monday (October 12, 2015) because we were "short-staffed" and did not have a bath aide available.

During interview on 10/14/15, at 1:16 p.m. NA-I stated, "staffing is an issue," big time, "baths do not get done" like they are suppose to. NA-I further stated, I often go home and cry that our residents "are not getting the care they deserve."

R24's annual MDS dated 7/22/15, indicated R24 had intact cognition, and required extensive assistance with most activities of daily living, including transferring and bathing.

During an interview on 10/12/15, at 6:15 p.m. R24 stated he was "supposed" to get a bath on Monday and Thursday, and preferred to have it right away in the morning, "So I don't have to get dressed twice." Further, R24 stated he does not consistently get his baths "because they're short staffed", and added he did not receive his bath today (10/12/15). On 10/13/15, at 3:44 p.m. (the following day) R24 stated he still had not been given a bath.

During observation of morning cares on 10/14/15,

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at 7:54 a.m. NA-A asked R24 when his bath day was, to which R24 responded, "It was supposed to be Monday [10/12/15], but I didn't get it." NA-A did not respond, and completed getting R24 ready for the day. At 3:15 p.m., R24 stated he still had not had a bath.

A Resident Choices For Bathing document dated 7/2/14, indicated R24 would like two baths in a week, in the morning. The Bath Schedule AM document dated 9/21/15, indicated R24 had a whirlpool bath scheduled on Monday and Thursday.

R24's bathing documentation from 10/1/15-10/19/15, indicated R24 had received a bath on 10/1/15, 10/5/15, 10/8/15, and 10/15/15. R24 did not receive a bath on 10/12/15 or 10/19/15.

During an interview on 10/15/15, at 7:06 a.m., NA-I stated there was no bath aide on those days so, "They [residents] didn't get their baths."

In an interview on 10/16/2015 at 11:03 a.m., licensed practical nurse (LPN)-A stated the "charge nurse" was to monitor the bathing, and "every once in a while, we get behind." LPN-A stated one bath aide "is compounded with a lot," and that the bath aide puts the missed baths on her schedule, trying to get them done. LPN-A said the frequency of bathing for residents in the facility "has declined."

When interviewed on 10/16/15, at 12:02 p.m. the director of nursing (DON) stated two bath aides were currently off work, but they were looking and "training staff for a back-up." The DON stated "we recognize that staffing is an issue."

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F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor, assess, and implement and/ or revise interventions to prevent pressure ulcers from developing, and to ensure healing of current pressure ulcers for 2 of 2 residents (R53, R14) reviewed for pressure ulcers. This resulted in actual harm for F53 who had recurring, multiple pressure ulcers. Findings include: R53 sustained harm when he developed two stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcers to the left and right heel, and a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer to the coccyx. The facility failed to monitor and comprehensively assess pressure ulcers as they developed; failed to notify the physician of the development of pressure ulcers	F 314	A: R14 and R53 were reviewed by Dietitian, WOC, and nursing to assure proper interventions in place for ulcer treatment/prevention such as dietary supplement, change in wound orders and change in support surfaces. B: All residents have been assessed for pressure ulcer risk. Residents with a Braden score of 14 or below have had interventions reviewed to ensure adequate prevention of avoidable skin breakdown. All residents were reviewed for proper interventions r/t risk assessment and baseline skin observations completed. C: Case managers educated on following the pressure ulcer policy and procedure. All nurses educated on the use of the pressure ulcer wound sheets to ensure all aspects of the ulcer are addressed. LPN charge position created to assist the case managers in redistribution of workload to ensure assessments of wounds are completed. It was reviewed with	11/30/15

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F 314	Continued From page 45 to assure proper treatment; failed to obtain physician direction of treatments and to notify the physician when changes were made for treatment of the pressure ulcers; failed to perform ongoing assessment of the pressure ulcers; failed to assess the cause of each pressure ulcer as they developed; failed to evaluate and/ or modify pressure ulcer treatments; and failed to follow care planned interventions that were in place. R53's annual Minimum Data Set (MDS) dated 6/17/15, indicated R53 had severe cognitive impairment and had diagnosis including diabetes, peripheral vascular disease, and cerebrovascular accident (CVA) with hemiparesis (weakness on one side of the body). The MDS also indicated R53 was at risk for developing pressure ulcers, but had no current pressure ulcers, and there were no pressures ulcers on the prior assessment. R53's pressure ulcer Care Area Assessment (CAA) dated 6/17/15, indicated R53 was, "At risk for skin impairment and breakdown r/t [related to] s/p [status post] [following] CVA /TIA [transient ischemic attack] [mini stroke] w/ [with] (L) [left] hemiparesis, Alz [Alzheimer's] dementia, requiring assistance w/ all mobilities and toileting needs, bowel and bladder incont [incontinence], inability to communicate needs effectively at times, Dx [diagnosis] of DM [Diabetes Mellitus], PVD [peripheral vascular disease] w/Hx [history] of PU [pressure ulcer] to heels. Admitted [R53] to facility last year with (B) [bilateral] hamstring contractures which increases risk for pressure ulcers to heels/feet." R53's CAA also included, "No current skin issues. Heels intact." The CAA included interventions including; staff to reposition	F 314	CNAs/Bath Aids on an immediate notification to a nurse of any new skin issues. Reviewed with CNAs about repositioning/toileting plans and implementing those. Pressure ulcers have been included as a Quality improvement process. D: All wound documentation and interventions will be audited by DON or designee weekly x4 weeks then biweekly x 1 month then monthly throughout the following year with results reported to Quality Council. DON/Designee to audit 10% of toileting plan/repositioning compliance weekly x4 weeks, Bi-weekly for a month then quarterly throughout the following year with results reported to Quality Council.	

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R53 every two hours, have the resident wear heel protectors while in bed, use of an alternating pressure mattress and a cushion in the wheelchair, and skin monitoring with daily cares.

R53's most recent quarterly MDS dated 9/16/15, indicated R53 continued to be at risk for pressure ulcers, and had one stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) that was not present on the prior MDS assessment, dated 6/17/15.

During an observation on 10/14/15, at 9:27 a.m., nursing assistant (NA)-B was assisting R53 with morning cares. R53 had a blue heel boot on the right heel, was wearing only a white sock on the left foot, and both heels were directly on the bed. R53's bottom sheet on the bed had numerous areas of drainage. NA-B removed the heel boot from the right heel, and there was a saturated dressing covering the lateral heel. NA-B then removed the sock from the left foot, which had a beefy red colored pressure ulcer approximately 2 cm, with 2 cm of surrounding tissue that had a pasty white color located on the medial left heel. NA-B stated she had never worked with R53, and she needed to find the nurse to have the pressure ulcer on the left heel covered. The blue heel boot for R53's left heel was observed laying in R53's recliner, and was not on his left heel. The blue heel boots were noted to be cloth foam boots which velcroed on the foot and leg, however, the heel was still touching the boot and pressure was not relieved from the heel (s)while wearing the blue boot.

On 10/14/15, at 9:49 a.m. licensed practical nurse (LPN)-B entered R53's room per NA-B's request

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with dressings and a culturette. LPN-B removed the saturated dressing from the right heel and cultured the drainage on the right heel pressure ulcer. The right heel pressure ulcer was observed to be approximately 2-3 cm, beefy red, with surrounding tissue that had a pasty white color. LPN-B stated she worked with R53 daily, and knew about the pressure ulcer on the right heel however, she was not aware R53 had a pressure ulcer on the left heel also. LPN-B directed NA-C to summon registered nurse (RN)-C to assess R53's pressure ulcers on the heels. RN-C entered R53's room and stated she was aware R53 had a left heel pressure ulcer, but she was not aware it was open. RN-C observed R53's right heel pressure ulcer and identified it as a "stage 3" pressure ulcer, and stated the right heel appeared "Swollen" however RN-C did not measure the right heel pressure ulcer. RN-C did measure the left heel pressure ulcer at that time and described it as, "4.5 centimeters [cm] in length with 2 cm open, and 3.7 [cm] width; with 1.2 c.m. actual open area." RN-C was unsure what stage the left heel pressure ulcer was.

During interview on 10/14/15, at 10:29 a.m. LPN-B stated the nursing assistants should be informing the licensed staff if they note any resident skin concerns however, LPN-B was not aware of R53's left heel pressure ulcer until this morning and stated, "No one had reported it." R53's Skin Risk Assessment with Braden Scale (a tool used to determine pressure ulcer risk) tool dated 6/11/15, identified the resident had a score of 18, which indicated R53 was at risk for pressure ulcer development. The assessment also indicated the resident had no current skin impairments/ pressure ulcers at the time of the assessment.

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The next skin assessment completed for R53 was titled Observation Report, which included a summary under the Quarterly Review section dated 9/4/15, which indicated R53 continued to be at risk for skin breakdown and included; "Does have h/o [history of] pressure ulcer to L [left] heel, due to contractures to hamstrings and knees are bent putting pressure on the heels. Staff to apply (B) [bilateral] heel boots while in bed...Has had an open area to his lateral heel that appeared as a broken blister related to shoe slipping as he was propelling himself around in WC [wheelchair]." The assessment did not indicate which heel had the pressure ulcer, and the assessment identified interventions for staff to continue the repositioning plan of every 2 hours. Although the assessment indicated R53 had developed an "open area," there were no new interventions developed to relieve pressure from R53's heels such as floating the heels, or applying heel boots which would relieve pressure vs providing only protection to the heels.

The undated Glenoaks Care Center-Maple 1 nursing assistant care sheet, (a direction for staff on specific cares for residents) directed staff to place the blue heel boots on R53 while in bed and recliner. The care sheet lacked direction to staff regarding repositioning R53 every two hours as assessed, and there was no direction to staff to monitor R53's skin for pressure ulcers. The nursing assistant care sheet did not give any direction to staff regarding repositioning or indicate R53 had, or was at risk for, pressure ulcers.

R53's Resident Progress Notes from 8/13/15-10/14/15, identified the following:

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8/13/15- R53, "Noted to have an open area on his (L) [left] lateral heel with is [sic] bath. States he is not aware if his shoes rub. Appears as blister that perhaps opened up and measures 1.1 x 1.1 cm [centimeters]. After his bath, foam dressing was applied. Instructed staff to leave his shoes off and grippy sock was applied. Nursing will monitor area." The note did not identify the stage, appearance of the wound bed, wound edges, surrounding skin, or the depth of the pressure ulcer. There was no indication if R53 had any drainage or discomfort from the pressure ulcer. When interviewed on 10/16/15, at 8:55 a.m., director of nursing (DON) stated the progress note on 8/13/15, should have identified the right heel had the pressure ulcer, not the left.

8/14/15- "Resident's heel is possibly from friction from his shoe constantly rubbing to the lateral part of his foot when he is self propelling in w/c [wheelchair]. This appears to be a Stage 2 PU [pressure ulcer]. Foam dressing is clean, dry, and intact. Will have staff not put shoes on either feet and only grippy socks." The note did not identify which heel had the pressure ulcer, however, the Resident progress note also indicated, "Checked (L) heel as well and was slightly red but blanchable." The note did not include a measurement of the red area on the left heel.

8/14/15- "MD updated on PU to (L) heel and left message for daughter." A corresponding fax to MD-A dated 8/14/15 included, "Resident has a stage 2 pressure ulcer to his (L) heel. Measuring 1.1 cm x 1.1 cm. Appears to be from rubbing on his shoes when he would self propel himself in the w/c [wheel chair]. Currently has foam dressing in place to keep wound clean and

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provide protection. He is going to have grippy socks on...until the wound is healed. Also will be having blue boots [heel protectors] on when he is in the recliner and in bed." The fax did not include any recommendations from MD-A, nor did the facility receive a response from MD-A verifying the information was received and reviewed. When interviewed on 10/16/15, at 8:55 a.m., DON again stated the pressure ulcer was actually on R53's right heel, and not the left.

8/20/15- "PU to left heel intact." The Progress Note did not include any measurements or description of the pressure ulcer. During interview on 10/16/15, at 8:55 a.m., DON again stated the pressure ulcer was actually on R53's right heel, and not the left.

8/21/15- "Continues to have an area on his (R) lateral heel. No drainage. No dressing was on this. Applied a foam dressing." The note did not identify the stage, measurements, appearance of the wound bed, wound edges, surrounding skin, or the depth of the pressure ulcer. There was no indication if R53 had any drainage or discomfort from the pressure ulcer.

The next Resident Progress Note or assessment regarding R53's pressure ulcer (s) was dated 9/3/15, 13 days later, which indicated R53's pressure ulcer was located on the (R) lateral heel, and measured 0.2 x 0.2 cm, with a small amount of serous drainage. The resident denied any pain, the area was cleansed with normal saline and a foam dressing was applied. The note also included, "Much improvement noted in the healing. ARea [sic] is showing good signs of healing." The note did not identify the stage of the pressure ulcer, appearance of the wound bed,

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wound edges, the skin surrounding, the wound, or the depth of the wound.

9/5/15- "Resident continues to have a small non-blanchable redden [sic] area to (R) lateral heel. Area measures 0.5 x 0.5 cm. Skin is intact. No drainage noted. Changed dressing to a Tegaderm Foam Adhesive dressing."

9/13/15- "Dressing changed to (R) heel d/t [due to] serous [bodily fluid typically pale yellow and transparent] drainage. Has loose dry skin on heel that hampered the adhesion of the dressing. Cleansed and dressed, pressure relieving boot reapplied." The note did not identify the stage, appearance of the wound bed, wound edges, surrounding skin, or the depth of the pressure ulcer. There was no indication if R53 had any discomfort from the pressure ulcer.

9/15/15- "Skin. No complications or concerns noted at this time. Skin is intact. No redness, pain, bruises, edema or sores noted." The heel pressure ulcer (s) were not addressed in this progress note, nor was there any indication the pressure ulcer had healed.

9/16/15- "Dressing changed on Rt [right] heel, no drainage noted on old dressing. Has a loose piece of skin covering wound, no signs of infection. New Tegaderm Foam adhesive applied." The note failed to include the size, the appearance of the wound, the skin surrounding the wound, and failed to note if the resident was experiencing any pain.

9/19/15- "Resident continues to have an area to (R) lateral heel. No drainage noted. There is a layer of skin that is hard and starting to come off.

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Left area OTA [open to air] and apply Eucerin cream to heels." The note failed to include the size, the appearance of the wound, the skin surrounding the wound, and failed to note if the resident was experiencing any pain.

9/22/15-"Continues with dry are [sic] to R [right] heel. Resident was wearing shoes when writer came on shift so tennis shoes removed." No further assessment of the pressure ulcer was documented.

9/23/15- Indicated R53's right foot was more swollen than the left, however, there was no assessment of the pressure ulcer to determine if there was healing, nor was there any indication the physician had been notified.

The next progress note regarding R53's pressure ulcer was 10/4/15, 11 days later which indicated, "On last rds [rounds] Sept 25th resident had a small dried callous area to (R) lateral heel and appeared it would fall off. Today staff alert writer that area was dark in color. Area measures 3.5 x 4 cm and is a thicker callous area, with a darker pigment almost black in color under the callous area. Area is not open, no drainage noted. Applied ABT [antibiotic] ointment to area and covered with Tegaderm Foam Adhesive." The note did not assess the ulcer to include the pressure ulcer stage, what the surrounding tissue was, or if R53 was experiencing pain. There was no corresponding assessment from the rounds which were completed on 9/25/15, which was referred to in the above assessment.

10/5/15- Indicated MD-A and R53's family were updated on right heel pressure ulcer and the current treatment staff was using was applying

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antibiotic ointment and covering with Tegaderm Foam Adhesive dressing. There was no indication what information was shared with MD-A, nor was there any changes to the treatment for R53's right heel pressure ulcer.

10/6/15- "R heel intact."

10/11/15- "Put new dressing to heel d/t not having one on there. Noted to have clear drainage on sock." The note failed to identify if they were referring to the right or left heel, and there was no further assessment and/ or description of the pressure ulcer.

10/13/15- "Dressing changed to R heel pressure ulcer d/t fully saturated. Serousanguinous [light yellow with small amounts of blood] fluid noted on dressing with some odor noted. Area cleansed with NS [normal saline], slough/dead skin noted to outer edges of wound, yellow slough noted to edges of wound 20%, beefy red in middle of wound 80%. Resident denied any pain to area. Treatment changed from check daily and change every 7 days and PRN [as needed] to check every shift and change daily or PRN if more than 50% saturated. MD [MD-A] updated on status of wound. Awaiting reply."

10/14/15- 8:21 a.m. "Received fax order from [MD-A]... WC [Wound Ostomy and Continence Care] nurse referral made, and culture wound."

10/14/15- 10:50 a.m. (after observation was completed) "Resident's R heel wound remains open and draining Serousanguinous fluid. Stage III [3] at this time. Wound culture obtained and sent to lab per MD order. Resident also has a referral to WOC nurse. Resident noted to have L

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lateral heel PU Stage III with Wound bed measures 2.0 cm x 1.2 cm with 2.5 cm x 2.5 cm of divitalized skin around wound bed. Wound cleansed with NS, skin prep applied and covered with Tegaderm Foam dressing. Resident currently has an air mattress on bed, wears heel boots while in bed, only wears socks with no shoes, has been referred to WOC nurse, culture obtained on wound. MD [MD-A] to be updated on new PU to L heel. Potential for referral to Hagen Orthotics for protective AFO's [a plastic brace to support the foot and ankle in the proper position] for his heels while in bed d/t resident having have [sic] knee flexion contractures and when resident is in bed most pressure is put on his lateral heels. This current wound is a suspected deep tissue injury r/t this issue. Daughter also updated on this plan."

Although on 10/14/15, at 9:49 a.m. R53 was observed to have pressure ulcers to both the right and left heel, there was no assessment or monitoring of R53's left heel pressure ulcer until 10/14/15, at 10:50 a.m.

R53's care plan dated 9/16/15, identified R53 was at risk for skin impairment and had no current skin issues including, "Heels intact." The care plan directed staff to monitor skin with daily cares and bathing, place heel protectors on while in bed, turn and reposition the resident every two hours and as needed, lotion heels at bedtime, and to monitor for changes in condition/skin, and update the medical doctor (MD) as needed. Even though the facility documented R53 developed a pressure ulcer on the right heel on 8/13/15, the facility had not updated the care plan interventions to prevent additional pressure ulcers from developing, nor did the facility make any changes to ensure R53 did not continue to have

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pressure on his heels to ensure healing of the current pressure ulcers.

Review of R53's Treatment Flowsheet, dated 8/1/15-8/31/15, included, "Heel boots on while in bed, check for proper placement. Every shift." A undated, handwritten note was added which indicated to wear the heel boots in recliner also. Although the facility identified R53 had a pressure ulcer on his right heel on 8/13/15, there was no treatment ordered/ documented on the Treatment Flowsheet for August 2015, to the current heel pressure ulcer(s).

R53's Treatment Flowsheet, dated 9/1/15-9/30/15, included, "Check (R) heel dressing daily and change weekly on Thurs [Thursday] til healed. Once a Day on Thu [Thursday]." This was implemented on 9/3/15. An undated, handwritten note was added next to the order which included, "foam dressing" and "Tegaderm Foam Adhesive." R53's Treatment Flowsheet also included a handwritten note, implemented 9/19/15, which directed, "Check R heel q [every] NOC [night] notify if getting worse & make sure Eucerin is applied. The Treatment Flowsheet was initialed by staff to indicate the right heel pressure ulcer dressing was changed on 9/3/15, 9/5/15, 9/15/15, and was then left open to air on 9/19/15. Review of R53's medical record indicated the changing treatment to R53's pressure ulcer were nursing orders, not treatment orders obtained from the physician.

R53's Standing Orders signed by the physician dated 4/26/14, directed staff, "May treat Stage I decubitus [pressure ulcer] per nursing order. Notify MD of stage 2 or greater ulcer for approval of treatment protocol." There is no indication the

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facility communicated with the physician and followed up to determine appropriate treatment for R53's worsening pressure ulcer until 10/13/15, nearly two months after the facility first noted the right heel pressure ulcer.

R53's Physician Progress Note written by MD-A dated 9/25/15, indicated R53, "Complains today of left heel pain. It mainly happens at night time in the area where his healed ulcer is... There are no ulcers or openings on his left heel noted where he is having pain."

During interview on 10/19/15, at 3:33 p.m. MD-A stated during R53's visit on 9/25/15, she had assessed R53's left heel pressure ulcer and it was not open, however, she did not assess the residents right heel pressure ulcer at this time, as she was not aware the resident had a pressure ulcer on the right heel. MD-A stated she was not aware of R53's right heel pressure ulcer until 10/14/15, when the facility notified her of the stage 3 pressure ulcer on the left heel. MD-A stated she had never received a fax in August (8/14/15) regarding R53 having a stage 2 pressure ulcer to his left heel.

During interview on 10/14/15, at 1:50 p.m. RN-C stated she was new to her role, and the RN who had the position prior to her had a binder she used to document wound cares, however, RN-C stated she had been unable to locate the documentation. RN-C stated she had not had any training regarding pressure ulcer and wound care, but she was planning on going with RN-B when she did wound rounds so RN-B could educate her on pressure ulcer treatment, assessment, and documentation.

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During a follow-up interview on 10/14/15, at 3:20 p.m. RN-C stated a call had been placed to the previous RN that held her position and was told there was no wound care binder; and any assessment and monitoring of resident pressure ulcers would be found in the Resident Nursing Progress Notes.

During interview on 10/16/15, at 12:56 p.m. NA-G stated she occasionally assisted R53 with cares, and indicated staff were directed to put blue boots (heel protectors) on R53 to protect his heels when he was in bed or in the chair.

R53's Resident Progress Note dated 10/18/15, indicated "Dressing changed to (B) [bilateral] heel this am d/t dressings coming off. Both heels were cleansed with NS, skin prep applied, and covered with Tegaderm Foam dressing and wrapped with kerlix [dressing applied to a wound] for security. Heel boots where [sic] both in place while in bed/recliner. No other skin issues to feet noted. Both wounds still noted to have eschar [thick, black, dry necrotic tissue] in place."

An additional Resident Progress Note dated 10/18/15, indicated, "Res (resident) noted to have a stage 2 pressure ulcer to coccyx this am. Very first layer of skin is off. Measure 1 cm x 2 cm, depth n/a. Wound bed red with no drainage. Res peri skin [skin surrounding wound] is blanchable."

R53's Resident Progress Note dated 10/19/15, indicated, "Resident had a shower this a.m., both dressings, one on RT and Lt heel were 50% saturated. Both dressings were very foul smelling, drainage was a green-tan in color. Did c/o [complain of] pain when old dressings removed,

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was repositioned which did not help, was medicated with Tylenol 650 mg [milligrams] at 7:00 a.m. Areas cleansed with NS, covered with Tegaderm foam adhesive and wrapped with Kerlix to prevent dressings from falling off. Heels are elevated off the EZ chair, has edema present on top of both feet."

A Glenoaks Problem/Fax Sheet dated 10/19/15, sent to MD-A indicated, "1.) Attached are the results of the resident's R heel wound [culture]. Heavy growth noted of proteus species and moderate growth noted to Klebsiella pneumonia. Attached are also culture/sensitivity. Resident will be seeing WOC nurse tomorrow afternoon for bilateral heels which are worsening and Stage II PU noted to bottom over the weekend. 2.) Which antibiotic would you prefer to start resident on? Any other orders?" MD-A responded with orders for Augmentin 875 mg twice daily for 7 days. Although the facility notified the physician of the new stage II pressure ulcer on R53 coccyx, no treatment options were reviewed, and the MD was not made aware of the measurements of the new stage II pressure ulcer to R53's coccyx.

Another fax was sent to MD-A on 10/19/15, indicating, "Okay to start resident on Juven [protein drink used to aid with wound healing] 1 packet with 8 oz (ounces) of fluid BID between meals for open areas to Bil (bilateral) heels and Stage II PU to coccyx?" MD-A replied with, "Yes."

During interview on 10/19/15, at 9:41 a.m., NA-J stated staff were directed to put heel boots on both R53's feet without socks. NA-J stated this recommendation had been made within the last three weeks because, "[R53] had sores on both heels."

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During interview on 10/19/15, at 9:44 a.m. NA-K stated R53, "Has trouble with his feet," and should not be wearing shoes or socks. NA-K stated R53 had pressure ulcers on both heels, and she believed it started on the right heel first, and then developed a pressure ulcer to the left heel, "It's been a month that he's had both [pressure ulcers to both heels]." NA-K stated she was directed about 3 weeks ago to only put the boots (heel protectors) on R53, and not to put any socks on the resident.

During interview on 10/20/15, at 9:02 a.m. DON stated when staff notified the physician via fax regarding R53's pressure ulcer on 8/14/15, staff should have followed up if they did not receive a response from the physician to ensure there was not a treatment change that needed to be completed. DON stated it was difficult for her to know what took place when R53 developed the first pressure ulcer to the right heel because she was not employed at the facility. DON stated, "The policies and procedures were in place; The procedure wasn't being followed."

R14's annual MDS dated 9/8/15, identified R14 had no cognitive impairment, and required extensive assist of two staff for bed mobility, transfers, and toileting.

R14's Care Plan dated 9/18/15, identified the resident was at risk for skin breakdown related to pressure, and R14 was assessed to be turned and repositioned every two hours. Interventions included extensive assist of two staff with repositioning routinely every two hours and as needed, monitor for recurrence of previous

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pressure ulcer areas, and encourage use of bed and side-lying when in bed. It also identified wound care was to be completed per wound, ostomy, and continence nurse.

R14's Physician progress note dated 9/22/15, indicated R14 had a pressure ulcer to her buttock. No staging, measurements, or further assessment of the pressure ulcer was noted. A Referral was made to the wound ostomy clinic.

R14's Wound Ostomy Continence (WOC) nurse progress notes dated 10/2/15, indicated R14 was to be frequently repositioned hourly when seated in her chair.

On 10/13/15, at 3:42 p.m. R14 was observed lying on her back in bed. R14 stated she did not receive the assistance she needed from staff with repositioning, and she had a "sore" on her buttocks. R14 stated the wound nurse stated she should be turning and repositioning often to relieve pressure, however, she stated she does not get repositioned that often, and, "Is lucky to get help once during the day and once at night." R14 was teary eyed and speaking with a cracking voice.

Review of R14's progress notes dated 9/8/15 - 10/16/15, identified the following:

- 9/8/15- "Resident c/o [complained of] her buttocks where she has some open sores." There were no measurements or description of the "open sores."
- 9/14/15- Open area to buttock appears slightly larger than a 50 cent piece.
- 9/9/15- Open area is currently slightly larger than a 50 cent piece.

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F 314	Continued From page 61 - 9/16/15- Area has increased to 12 centimeters (cm) x 3 cm, almost all open except a few areas to the top and bottom, and surrounding tissue is purple. - 10/5/15- "Appears to have more open areas near rectum this am [morning]." There was no corresponding assessment of the open area. - 10/16/15- "Stage II pressure ulcer to buttocks. Erythema across buttocks 11.5 x 8.5 cm. Previous Stage II area on right buttock cheek appears sealed over but is darker Erythema measuring 1.5 x 0.6 cm." During continuous observation of R14 on 10/14/15, from 7:01 a.m. through 9:45 a.m. the following was observed: - 7:01 a.m.- R14 was lying in bed on her back. - 8:35 a.m. NA-C asked R14 if she wanted to get dressed, R14 stated she was not ready to get up yet. NA-C offered R14 coffee, which was declined, and NA-C left the room. R14 was not offered toileting or repositioning. - 9:29 a.m. LPN-C entered R14's room with her medications. R14's head of the bed was raised, and R14 told LPN-C her heels were sore. LPN-C placed pillows under R14's feet, however, no toileting or repositioning was offered. Although R14's care plan indicated R14 was at risk for pressure ulcers and was to be repositioned and toileted every 2 hours, the resident was observed for 2 hours and 28 minutes without being offered assistance with repositioning or toileting. During interview on 10/14/15, at 9:40 a.m. LPN-C stated R14 was to be repositioned and offered toileting every two hours, and stated the resident should not have gone 2 hours and 40 minutes	F 314		

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without staff offering to toilet or reposition the resident.

On 10/14/15, at 9:44 a.m. LPN-C and NA-D entered R14's room and assisted R14 onto her right side. R14 was offered toileting at this time, but refused.

During a follow up interview on 10/14/15, at 1:09 p.m. R14 stated it is common to put the call light on and wait 15 - 20 minutes for staff assistance, and stated she is frequently incontinent before assistance arrives. R14 also stated staff will walk by when the call light is on, say they will be back, and then turn the call light off without providing assistance.

During interview on 10/14/15, at 1:46 p.m. RN-B stated R14 is frequently incontinent of bowel and bladder, and believed staff should be offering R14 assistance with repositioning every hour.

On 10/15/15, at 2:35 p.m. RN-B was observed performing a dressing change to the pressure ulcer on R14's buttock. RN-B removed the old dressing and stated the dressing appeared to be completely soiled with feces, and it would be her expectation the nursing assistants would report to nursing if a dressing was soiled so it could be changed. RN-B assessed R14's buttocks and stated the reddened area measured 11.5 cm x 8.5 centimeters (cm), and the smaller, deeper red area measured 1.5 x 0.6 cm. She stated the pressure ulcer was previously a stage II, but was now a stage I as it was not open.

During interview on 10/16/15, at 8:48 a.m. NA-L stated she believed R14 was to be assisted with repositioning every two hours.

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F 314	Continued From page 63 During interview on 10/16/15, at 10:28 a.m. NA-D stated she believed R14 was to be offered toileting and repositioning every hour, and was always incontinent. During interview on 10/16/15, at 10:58 a.m. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when sitting. RN-A stated R14 would refuse toileting and/ or repositioning at times, however, staff should still be offering and encouraging R14 to toilet and reposition to ensure healing of the pressure ulcer. The facility policy titled, Prevention and Treatment of Skin Breakdown dated 10/10 included, "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." The policy directed if a resident was admitted with, or there was a new development of a pressure ulcer, staff were to notify the physician, dietary, therapy, and the care plan and nursing assistant care sheets with skin concern would be updated. Staff were directed to initiate the Initial Pressure Ulcer Documentation form and the Weekly Ulcer Documentation form, and were to complete daily wound monitoring which included observation of the pressure ulcer or the status of the dressing, area surrounding the ulcer, presence of possible complications such as signs of infection, assess pain management, and to document any changes or concerns in the nurses notes. The facility policy titled Weekly Ulcer	F 314		

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F 314	Continued From page 64 Documentation Form Procedure dated 10/10 directed, "The Initial Ulcer & Weekly Ulcer Documentation form should be started immediately upon identification of pressure ulcer...should be completed at least weekly and as appropriate." The policy directed staff to document stage, length, width, depth, drainage, odor, undermining, tunneling, wound edges, and wound progress, and to notify the physician of any changes.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting for 1 of 2 residents (R14) reviewed for urinary incontinence, and who was dependent upon staff for toileting. Findings include: R14's annual Minimum Data Set (MDS) dated 9/8/15, identified R14 to be cognitively intact, require extensive assistance with activities of	F 315	A: Identified resident□s toileting plan was reviewed and staff aware of current toileting program via care sheets. Resident refusals are being promptly reported to nurse and documented. B: All residents with routine toileting plans could be affected were reviewed. C: It was reviewed with staff re: the importance of following routine toileting plans for all residents and promptly notifying nurse of resident refusals.	11/30/15

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F 315	Continued From page 65 daily living (ADLs), and have frequent urinary incontinence. R14's Urinary Incontinence Care Area Assessment (CAA) dated 9/8/15, identified R14 to be incontinent of urine on the way to the bathroom. Further, the CAA identified staff were to, "...continue toileting plan of Toilet [sic] upon rising, Q2H [every two hours] during the day, and offer during the NOC [night]. R14's Bladder Assessment dated 9/9/15, identified R14 to have "mixed" incontinence, and listed a treatment program of, "Scheduled Toileting/Habit Training." Further, the assessment directed staff to help R14 to the toilet every two hours during the day. R14's care plan dated 9/18/15, identified a risk for incontinence with interventions including to help R14 with toileting upon on rising in the morning, every 1 1/2 hours when awake, every two hours at night, and per her request. During continuous observation on 10/14/15, from 7:01 a.m. to 9:44 a.m. R14 was laying in bed in her room. R14 was not offered or provided with any toileting or incontinence cares for 2 hours and 43 minutes. When notified of the lack of toileting or incontinence care for R14 on 10/14/15, at 9:40 a.m. licensed practical nurse (LPN)-C stated R14 should have been assisted with toileting every two hours. During interview on 10/14/15, at 1:09 p.m. R14 stated she will frequently put her call light on and have to wait for 15 to 20 minutes to receive help with toileting, often becoming incontinent before help arrives.	F 315	Agency staff orientation checklist has been updated to include explanation of the care sheets, repositioning and toileting records, and promptly notifying nurse of refusals of repositioning, toileting, and other assistance. D: DON/Designee to audit 10% of toileting plan compliance weekly x 4 weeks, biweekly for a month then quarterly throughout the following year with results reported to Quality Council.	

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F 315	Continued From page 66 When interviewed on 10/16/15, at 10:58 a.m. registered nurse (RN)-A stated R14 was to be offered toileting upon rising, and every one hour while she was awake. Further, RN-A added R14 should have been offered toileting before 2 hours and 44 minutes passed. A facility Urinary Continence and Incontinence - Assessment and Management policy dated 9/2010, identified staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections.	F 315		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently provide range of motion services for 4 of 4 residents (R17, R24, R3 and R29) in the sample reviewed for restorative nursing services. Findings include: R17's annual Minimum Data Set (MDS) dated 8/24/15, identified R17 had intact cognition, and	F 318	A: Residents identified are being assisted with ROM per care plan. B: All residents that require staff assist with ROM services were reviewed. C: Staff has been crossed trained in rehab/ROM to ensure that residents are receiving appropriate ROM services. D: Staffing coordinator to ensure that there is a Rehab aide 5 days a week to complete ROM/rehab. DON or	11/30/15

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F 318	Continued From page 67 required extensive assistance with most activities of daily living (ADLs). R17's ADL Function and Rehabilition Potential Care Area Assessment (CAA) dated 8/24/15, identified R17 had minimal movement of the left leg and no movement with the left hand, but was able to participate as desired with dressing and grooming. Further, the CAA identified R17 had worked with therapies in the past on several occasions. R17's care plan dated 9/2/15, identified R17 had hemiplegia (paralysis of one side of the body) and cerebrovascular disease, and identified an intervention of a restorative nursing program. The program included attending an "exercise group", and, "ROM [range of motion]" to his upper and lower extremities. Further, the care plan directed staff to "monitor for change" in R17's ability to participate in group exercises and assistance to complete his ADLs. R17's undated Restorative Nursing Program identified R17 should receive assisted active range of motion (AAROM), passive range of motion (PROM), and active range of motion (AROM) as follows: Upper Body: > AAROM to right (R) shoulder in flexion and abduction x (times) 10 repetitions (reps) each and; > AAROM (R) elbow in flexion and extension x 10 reps and; > AAROM (R) wrist in flexion and extension x 10 reps and; > AAROM to (R) fingers: make and open fist and spread fingers apart for 10 reps and;	F 318	designee will review 10% of the documentation of ROM services weekly x 4 weeks, monthly x 3 months, then quarterly throughout the following year with results reported to Quality Council.	

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> PROM to left (L) shoulder in flexion and abduction x 10 reps each and;
> PROM to (L) elbow in flexion and extension x 10 reps and;
> PROM to (L) wrist in flexion and extension x 10 reps and;
> Passively stretch fingers and thumb of left hand to tolerance for 1 minute.

Lower Body:
> Passive hamstring stretches to bilateral (both sides) lower extremities for 3-5 minutes (could be done while performing upper body activities) and;
> AROM to AAROM (R) and (L) hop flexion x 10 reps and;
> AROM to AAROM (R) and (L) knee extension and flexion (kicks) x 10 reps and;
> Heel cord stretches bilaterally for 1 min each.

During observation on 10/14/2015 at 8:22 a.m., NA-A and NA-B assisted R17 in his room to transfer from the toilet into his wheel chair using a mechanical lift. R17 was able to bear weight during the transfers, and hold on to the standing device using his right hand and arm.

R17's Restorative Flowsheets from 7/1/2015 to 10/10/2015 were reviewed and identified R17 received the following documented ambulation services:
> July 11 of 13 opportunities
> August 5 of 13 opportunities
> September 4 of 13 opportunities
> October 1 of 4 opportunities

In an interview on 10/16/2015 at 9:41 a.m., registered nurse (RN)-A stated the "nurse managers" were in charge of the restorative programs, that they reviewed "their own resident"

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and "should be monitoring progress, as well if the programs "are getting done or note." RN-A said she "did not know" if the programs were getting done consistently. RN-A stated there was one primary restorative aide, and her back up is leaving the facility, right now have "not found someone who wants to step in."

In an interview on 10/16/2015, at 11:32 a.m. restorative aide (RA)-B stated she was supposed to see R17 "three times a week" for his restorative program, which included his upper and lower extremities. RA-B said R17 had "arthritis on his weak knee," but denied that R17 has had changes or decline in his functional abilities. RA-B also said R17 usually participated in a daily "wellness program" run by the activity department staff. RA-B stated the past few months she had been working "more on the floor" because the facility was "short staffed", and R17 was not getting his restorative program completed as it should have been. Further, RA-B stated she knew restorative programs were important, but there "was nothing we can do."

During interview on 10/20/2015, at 9:18 a.m. the physical therapist (PT) stated the facility "should have a stronger follow up program after residents are discharged from therapy." In the past, "we had a weekly meeting with the RN in charge of the resident and the rehab aid" and "every resident would be discussed" at least monthly, and it "did not matter" whether a resident was getting therapy or was on a range of motion or walking program." The PT said it was a way for us to "catch things" before a resident lost functionality. The PT said restorative programs "were not" consistently completed. The PT said it was difficult to get and retain qualified staff, but

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"we still have to take care of the residents."

R24's annual Minimum Data Set (MDS) dated 7/22/15, identified R24 had intact cognition, required extensive assistance of two staff for bed mobility and transferring, and had functional limitations in range of motion (ROM) with bilateral impairment to upper and lower extremities.

R24's ADL Function and Rehabilitation Potential Care Area Assessment (CAA) dated 7/22/15, identified R24 had hip and knee flexion contractures and limited ROM to bilateral upper extremities. Further, R24 had a restorative plan to help maintain his limited functioning.

R24's care plan dated 10/11/15, identified R24 had impaired functional range of motion with contractures to all extremities and included a goal to maintain the ability to bear weight for transfers and remain able to feed himself. The care plan identified interventions including for staff to provide massage to his neck prior to starting range of motion, passive range of motion (PROM) to left upper extremity, active assistive range of motion (AAROM) to right upper extremity, and bilateral lower extremity exercises with weights, knee extension, and hamstring curls.

During an observation on 10/12/15, at 6:42 p.m., R24 was sitting in a motorized wheelchair. R24 leaned slightly to the left, head and neck tilted to the left, hands were close to his body and closed, and lower extremities were bent at the knees. R24 moved his right arm occasionally, with right elbow bent.

During an interview on 10/13/15, at 3:44 p.m. R24

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stated he was "supposed to work" with the restorative aides three times a week, but it was not consistently getting done "because they're short of help." R24 stated when that happens, "I do as much as I can, myself."

R24's Restorative Flowsheet, dated 1/23/15, included, "Prior to ROM Start with Sombra [warming gel] massage to neck, stretch neck to decrease tone, then shoulders, elbow." Also included, staff were directed to provide PROM to left upper extremity, AAROM to right upper extremity, and 4# weights hip flexion, knee extension kicks, and hamstring curls with blue band 3 x 10 to bilateral lower extremities, on Monday, Wednesday and Friday.

R24's Restorative Flowsheets dated 7/1/15-10/20/15, identified R24's restorative program had been documented as completed as follows:

> July 2015 10 of 14 opportunities
> August 2015 6 of 13 opportunities
> September 2015 5 of 13 opportunities
> October 2015 1 of 8 opportunities

During an interview on 10/14/15, at 2:26 p.m. physical therapist (PT)-A stated when residents complete therapy a maintenance program is recommended, and becomes a nursing restorative program. Nursing was responsible to monitor the program and make sure its completed. Further, PT-A stated R24 should be having his restorative ROM program completed as directed to maintain his strength.

When interviewed on 10/16/15, at 7:59 a.m., restorative aide (RA)-A stated R24 should receive

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his restorative program three times a week,and the documentation on the Restorative Flowsheet was "accurate." RA-A stated he had been getting pulled to the floor to do cares instead of restorative programs, so they have been getting complete "less and less." Further, only two staff were trained to complete restorative programs, and the lack of the programs being completed was becoming upsetting to the residents, "Residents get frustrated when their exercises and walking aren't done."

R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 had moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff for transfers. Further, the MDS identified R3 had bilateral mobility impairments to the lower extremities, and received no days of completed ROM.

R3's care plan dated 9/30/15, identified an intervention for staff to complete ankle and foot PROM including dorsiflexion, plantarflexion with 15 reps each foot, heel cord stretches, up to three times weekly as R3 tolerates.

R3's Restorative Flowsheet dated 1/23/15, identified an order for bilateral ankle and foot passive range of motion (PROM) including dorsiflexion (toes upward), plantarflexion (toes downward) 15 reps each foot. Heel cord stretches (toes upward and hold 30 seconds, with three reps to each foot/ankle), once a day Sunday, Tuesday, and Thursday up to three times a week.

R3's Restorative Flowsheets dated 6/1/15 - 10/20/15, identified the ordered PROM had been

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documented as completed as follows:

> June 2015 10 of 13 opportunities
> July 2015 9 of 13 opportunities
> August 2015 4 of 13 opportunities
> September 2015 1 of 13 opportunities
> October 2015 1 of 13 opportunities

When interviewed on 10/16/15, at 8:07 a.m. restorative aide (RA)-A stated the provided restorative services are identified on the Restorative Flowsheet. The restorative programs are not being consistently completed as the restorative aides are pulled to the floor to help with cares due to being short staffed. RA-A is typically scheduled to work on restorative programs four days a week, but is consistently pulled away from them three of the four days. The nursing assistants (NA) are not trained, nor do they complete restorative programs. Further, RA-A stated these concerns had been reported to the former director of nursing (DON).

R29's quarterly Minimum Data Set (MDS) dated 8/29/15, identified R29 had long and short term memory problems, was totally dependent on staff for her ADLs, and had limitations in her ROM on both sides of her body.

R29's care plan dated 9/4/15, identified R29 was "at moderate risk" of contractures, and had "limited" ROM to her bilateral shoulders. Further, the care plan identified an intervention of, "PROM up to 3 X [times] weekly per therapy recommendations."

Review of the Restorative Flowsheet Records from 8/2015 to 10/15/15 identified that PROM was to be offered three times a week. The

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F 318	Continued From page 74 Restorative Flowsheet Records identified R29's received the following PROM: > July 2015 10 of 13 opportunities > August 2015 5 of 13 opportunities > September 2015 2 of 13 opportunities > October 2015 2 of 7 opportunities When interviewed on 10/16/15, at 7:59 a.m., restorative aide (RA)-A stated he had been getting pulled to the floor to do cares instead of restorative programs, so the restorative programs had been getting completed "less and less." Further, only two staff were trained to complete restorative programs, and the lack of the programs being completed was becoming upsetting to the residents. A facility Range of Motion Exercises policy dated 10/2010, identified staff should review the care plan and therapy recommendations prior to completing ROM for each resident, and document the date and time, type of exercise completed, and how long the exercise was completed for each resident.	F 318		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to 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. 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	F 353		11/30/15

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F 353	Continued From page 75 care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficent staffing to ensure the assessed needs and services were provided for 2 of 2 residents (R53 and R14) reviewed for pressure ulcers, which resulted in actual harm for R53. In addition, the facility failed to provide adequate staffing to ensure residents received required assistance with activities of daily living (ADL's) for 13 of 47 (R47, R35, R17, R24, R57, R33, R28, R53, R40, R17, R12, R57, R33) residents who resided in the facility needing staff assistance for ADL's, and/or who voiced concerns of insufficient staffing. Further, the faciltiy did not provide restorative nursing, for 4 of 4 residents (R17, R24, R3 and R29) reviewed for range of motion. The lack of staffing had the potential to affect all 47 residents in the faciltiy. Additionally, for lack of staffing concerns were expressed by 1 of 3 family members (FM-A), and 5 of 22 employees, (LPN-A, NA-D, NA-I, NA-O, and housekeeping assistant (HK)-A, expressed concerns about resident cares and treatments not being completed, or completed timely.	F 353	A, B, C: Sufficient staffing to be maintained by: Additional staff will be trained on restorative nursing and Baths to provide more flexibility with scheduling and emergency situations. Universal worker hours reviewed and additional hours were added during the day for non-nursing tasks to assist the CNAs. We are currently working with 4-5 pool agencies to assist in finding sufficient staffing. Ads placed for nursing staff with incentives highlighted (sign on bonus, flexible hours, scholarships, new wage scale). Program advertised to send potential employees through CNA class. Recruitment letter to be mailed out to Certified Nursing assistants in the surrounding geographic area for potential employment. Direct care staffing reviewed daily and adjusted to accommodate resident needs. Sufficient staffing including Bath aid hours and rehab hours have been added to the QA Agenda. Staff, Residents, and family will be asked about current staffing situation	

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F 353	Continued From page 76 Findings include: The facility failed to following morning routine preferences for 1 of 1 residents (R24) reviewed for choices. Refer to F242 for additional information. The facility failed to consistently provide or offer ambulation services for 4 of 5 residents (R35, R28, R53 and R57) reviewed for restorative nursing. Refer to F311 for additional information. The facility failed to provide bathing assistance for 6 of 7 residents (R17, R35, R57, R33, R47 and R24), who were dependent upon staff for bathing. Refer to F312 for additional information. The facility failed to implement interventions to minimize skin breakdown for 2 of 2 residents (R53 and R14) reviewed for pressure ulcers. This resulted in actual harm for R53, who had recurring pressure ulcers. Refer to F314 for further information. The facility failed to provide timely assistance with toileting to promote urinary continence for 1 of 2 residents (R14) dependent upon staff for toileting assistance. Refer to F315 for further information. The facility failed to consistently provide the necessary services to maintain range of motion for 4 of 4 residents (R17, R24, R3 and R29) reviewed in the sample. Refer to F318 for further information. RESIDENT COMPLAINTS R40's quarterly Minimum Data Set (MDS) dated	F 353	and if the residents needs are being met. These will be asked at resident council, care conferences, and with audit. D: Weekly audits of bathing/rehab. hours x4, biweekly x2 then monthly to be completed by staffing coordinator/DON on rehab/bath aid hours and reported to Quality Council. DON/Designee to audit 3 residents, 3 staff, and 3 family members a month to Inquire about staffing and if residents needs are met. Results of the staffing interviews will be reported monthly to Quality council.	

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6/30/15, indicated the resident had no cognitive impairment, and required physical assistance with bathing and supervison of staff for dressing, grooming, and mobility.

During interview on 10/12/2015, at 5:07 p.m. R40 stated the facility did not have a consistent bath aide, and she was supposed to be getting a bath twice a week, however, due to the lack of staffing, she did not recieve her bath when she was scheduled for it, and thought it had been about a week since she had recieved assistance with bathing.

R17's annual MDS dated 8/24/15, indicated the resident had no cognitive impairment, required extensive assistance for transferring, bed mobility, and most activities of daily living (ADLs).

During interview on 10/12/15, at 7:29 p.m. R17 stated he was supposed to get bathed twice a week, however, he does not always get his baths because there are, "Not enough people [staff] here" to assist with his bath. R17 stated, "It does make me upset that I don't get my bath."

R12's significant change MDS dated 9/9/15, indicated the resident had no cognitive impairment, and required extensive assistance for bed mobility, transferring, and most ADLs.

During interview on 10/12/15, at 6:50 p.m. R12 stated the facility needed more staff on all shifts, and she had soiled herself having to wait for assistance with toileting. R12 stated, "I don't like that," and stated waiting for help to the bathroom because they are short staffed, "Is something that shouldn't have to happen."

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R57's quarterly MDS dated 9/10/15, indicated the resident had no cognitive impairment, and required extensive assistance with transferring, walking, and most ADLs.

During interview on 10/12/15, at 6:30 p.m. R57 stated he was, "Frustrated," because he was not receiving his scheduled bath because the facility did not have enough staff.

FAMILY COMPLAINTS
Family member (FM)-A during interview on 10/13/15, at 10:57 a.m. stated the facility is short staffed, and feels that many of the departments have cut back on staff. FM-A stated even housekeeping had cut back on staff, and her mothers wheelchair is often dirty because there is no staff to clean it.

STAFF COMPLAINTS
Licensed practical nurse (LPN)-A during interview on 10/13/15, at 3:29 p.m.stated the facility often used pool nursing agency staff in the mornings to cover shifts, and resident baths were not getting completed due to the lack of staffing. LPN-A stated bath aides were needed to work as NA's (nursing assistant) on the floor, therefore, there was no staff to complete resident baths. LPN-A also stated the restorative aides were often pulled to work on the floor when they should be assisting residents with their restorative program, however, the facility was short staffed so they needed to assist with resident cares, therefore, the restorative programs were not being completed for residents.

NA-D during interview on 10/14/15, at 9:18 a.m.

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stated the facility did not currently have a bath aide, and it was difficult to complete resident baths. NA-D stated when there is a bath aide on the schedule, they, "Often get pulled to work the floor," to assist with resident cares because the facility does not have enough staff to provide the required resident cares.

NA-I during interview on 10/14/15, at 1:24 p.m. stated she, "Gets angry," when resident bathing does not get done, and had brought her concerns to the administration several times regarding the inability to complete resident cares related to short staffing. NA-A stated, "I know the turning, toileting, and repo [repositioning] are not getting done." NA-I stated breakfast also gets delayed because there was not enough staff to get the residents out of bed timely, and also basic grooming does not always get completed related to lack of staffing.

Housekeeping assistant (HK)-A during interview on 10/14/15, at 1:46 p.m.stated housekeeping hours had been cut down, and there were concerns of not having enough staff and time to ensure all cleaning duties were being completed. HK-A stated housekeeping was not always able to ensure deep cleaning of rooms, including wiping down baseboards, and wiping down walls and furniture were being completed related to the lack of staffing.

NA-O during interview on 10/19/15, at 3:12 p.m. stated R35 would be able to walk if staff would have time to walk her, however, the facility did not have enough staff to ensure the residents were being provided restorative care they had been assessed to recieve.

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F 353	Continued From page 80	F 353		

Staffing Coordinator (SC)-A during interview on 10/14/15, at 2:40 p.m. stated she was aware the bath aide and the restorative nursing aide get reassigned to assist with resident cares, "Quite a bit." SC-A stated she was aware residents had voiced concerns to the facility they were not receiving their baths, and the facility was currently working on trying to train in two additional bath aides. SC-A stated the facility had specific concerns with lack of staffing on the day shift (early morning), and the facility had been discussing solutions, and there is an ongoing request to present staff to assist with any open available hours. SC-A stated there were currently no changes related to taking admissions due to lack of staffing, and the facility was currently utilizing 4 different pool nursing staff agency's to work on the lack of staffing to provide the necessary resident cares.

In an interview on 10/16/2015 at 12:02 p.m., the director of nursing (DON) stated they had been "doing a lot of interviewing" regarding staffing, and acknowledged that it was often difficult "to get residents up in the mornings." The DON acknowledged staffing was concern for the facility, and the facility recently had "a wage increase," and also had "sign on bonuses" and were offering "more scholarships" to draw people in to work. The DON also said they were offering "flexible scheduling" to accommodate staff, were looking to post a position for "rehab" [restorative nursing], and were also looking to have "more staff trained and cross trained" for both bathing and rehab. The DON openly stated the facility recognized "staffing is an issue."

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F 353	Continued From page 81 During an interview on 10/20/15, at 9:49 a.m. the administrator, director of nursing (DON), and registered nurse (RN)-A all identiifed they had concerns with staffing in the faciltiy and were trying to resolve these issues.	F 353		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 431		11/30/15

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F 431	Continued From page 82 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 controlled substance medications were stored without evidence of tampering and to decrease the risk of diversion for 3 of 20 residents (R21, R41, and R7) reviewed for medication storage; and failed to ensure insulin was dated when opened to reduce the risk of administration after expiration for 3 of 7 residents (R53, R6, and R3) who received insulin in the facility. Findings include: IMPROPER STORAGE OF CONTROLLED MEDICATIONS: During observation of two separate mediation carts on 10/16/15, at 1:12 p.m. with licensed practical nurse (LPN)-A the following packages of medications were noted to have tablets of medication taped to the back of them: > Ativan (medication used for anxiety) 0.5 milligrams (mg) for R21. The package had one pill area taped on the back after being opened. > Oxycodone (narcotic pain reliever) 5 mg for R41. The package had two pill areas taped on the back after being opened. > Tramadol (opioid pain reliever) for R7. The package had one pill area taped on the back after being opened.	F 431	A: Staff referred to the date insulin pens were last checked for open dates and determined that pens were opened on or after this date. Pens were dated with the last date checked. B: Insulin pens and vials were reviewed on all medication carts for date opened. C: Nurses have been educated on the process of dating insulin and to follow the MAR verification dates. It was reviewed with staff on the importance of verifying open dates every time the pen is use to prevent risk for expired meds. D: All insulin pens and vials will be audited Weekly x4, biweekly x4 then monthly. To be completed by nurses giving insulin on medication carts, with results reported to DON or designee and Quality Council. A: Bubble packs that were noted to have tape on them immediately reviewed for pill imprint to ensure that there was no tampering. Packs were removed from the medication lock box that was taped. Notification sent out to staff that taping the bubble packs should never be done. B: All narcotic bubble packs were reviewed on 10/21/15 with no evidence of tampering. C: TMAs/LPN/RNs have been educated on not returning unused medications to	

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F 431	Continued From page 83 During interview on 10/16/15, at 2:27 p.m. RN-A stated she completed a monthly audit of the controlled substances, and noted some of the packages to have pills taped back inside after being removed. RN-A stated if a resident refuses a medication, or takes it to an appointment but does not use it, it is returned and taped back into the packaging to be reused later. Further, RN-A stated she was not aware of any facility policy which addressed this process. When interviewed on 10/16/15, at 2:51 p.m. the consulting pharmacist stated he had never noticed medications being taped back into the packaging during his visits, however added those medications need to be disposed of and not saved for use later on. During interview on 10/19/15, at 1:40 p.m. the dispensing pharmacist stated any medications not used after being removed from the bubble packaging needed to be destroyed, and not saved for use later on. When interviewed on 10/19/15, at 1:55 p.m. the DON stated any medications found to be taped on the back of the bubble packs will be removed and destroyed. A facility Controlled Substances policy dated 12/2012, lacked any direction or policy for when staff should return un-used medications to the packaging. A facility supplied All Staff Administering Medications at Glenoaks Care Center document dated 7/2015, identified if a resident refuses a medication, it should be destroyed or discarded.	F 431	the blister packs to be destroyed per policy. New Narcotic policy with indication on unused narcotics was reviewed with all nurses/TMAs. D: Narcotic Audit will be completed weekly x4 weeks then monthly to ensure narcotics have proper count, imprint, current use, and no evidence of taping or tampering present. Results will be monitored by DON or designee with results reported to the Quality Council.	

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F 431	Continued From page 84 UNDATED INSULIN: During observation of two medication carts in the facility on 10/16/15, at 1:12 p.m. with licensed practical nurse (LPN)-A, the following insulin flexpens were noted to be available for resident use: > Lantus (injectable insulin) flexpen labeled for R53. The flexpen was opened with doses removed, but not dated as to when it was opened to ensure it was not expired. > Lantus flexpen labeled for R6. The flexpen was opened with doses removed, but not dated as to when it was opened to ensure it was not expired. > Humalog (injectable insulin) flexpen for R3. The flexpen was opened with doses removed, but not dated as to when it was opened to ensure it was not expired. When interviewed during the observation regarding the lack of dating on the insulin, LPN-A stated the facility policy was to date insulin when it was opened to ensure it would not expire while still being used, and the flexpens should have been dated. During interview on 10/16/15, at 1:22 p.m. the director of nursing (DON) stated when insulin is removed from the refrigerator and opened, it is to be dated on the label. A facility Labeling of Medication Containers policy dated 4/07, identified labels for individual drug containers shall include all necessary information, such as the expiration date when applicable.	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		11/30/15

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F 441 SS=F	Continued From page 85 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 86 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an infection control program to include consistent monitoring, trending and analysis of infections to reduce the transmission to other residents in the facility. This had potential to affect all 47 residents residing in the facility. In addition, the facility failed to ensure handwashing was completed to reduce the potential spread of infection for 4 of 6 residents (R24, R31, R14, R57) whose cares were observed during the survey. Findings include: LACK OF COMPREHENSIVE INFECTION CONTROL PROGRAM: An untitled infection log document dated June 2015, identified a flowsheet for staff to record resident infections. The flowsheet identified seven residents experienced an infection in the facility since 6/1/15, with the last recorded infection being on 9/17/15. The flowsheet provided spaces to record the following information to track and trend infections: > Date > Resident Name > Organism/Culture Results > Room Number > If Present Upon Admission > Type of Infection (i.e. urinary tract infection [UTI], gastrointestinal illness [GI], etc.) and, > Antibiotic (with start and end dates). The flowsheet consistently identified the residents name, date of infection, and type of infection, however it lacked consistent organism	F 441	A, B, C: All staff will be trained on hand washing and handling of soiled linen. Hand washing was added to the orientation checklist for contract staff to complete prior to their work on the floor. Policy for soiled linens updated to include: always bag any soiled linens before leaving a residents room to transport. Nursing staff educated on not asking MD for recheck UA if symptoms have resolved. It was discovered to have 2 different infection logs in rotation. These were replaced with a consistent Infection log with "symptoms" added and notation if infection was cultured or not, and when symptoms/infection resolved date. Log created for symptoms such as Vomiting/cold symptoms tracking that would not be on the "infection log" due to not starting an antibiotic. Case Managers and infection control nurse educated on these Logs and the need for consistent documentation. D: Hand washing and soiled linen handling audit to be completed weekly for 4 weeks bi- weekly for 1 month then monthly. Results will be monitored by DON or designee with results reported to the Quality Council. Infection log and Symptom log will be audited on a monthly basis by DON or designee for completion of documentation with results reported to Quality Council. All residents with UTIs are being Audited on a monthly basis for inappropriate recheck Urinalysis with results reported to the Quality Council.	

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identification, and antibiotic start and stop dates as directed be filled out by the flowsheet.

A separate facility Care Center Infection log dated September 2015, was provided and identified a different flowsheet in which staff recorded infections. The form included spaces to identify the following information:
> Resident name
> Room
> If present upon admission
> Organism
> Type of infection (i.e. urinary tract infection (UTI), gastrointestinal infection (GI), etc)
The September 2015 data listed ten residents as having an infection for the month. R26, R28, and R29 were identified has having an "emesis" written underneath of the "Organism" heading, and were located in adjacent rooms on the Maple Lane unit. R26, R28 and R29 were all identified has having a "GI" infection on the report. Further, the report identified three residents had a UTI, two residents had a lower respiratory infection, and one resident had a skin infection. However, the log lacked consistent identification of the organisms causing the infection, symptoms of the infection, nor the date they started or resolved, documentation of the room for each resident, and the start or stopping date of antibiotics which were used to treat each resident. An undated facility September 2015 Infections report identified the documented analysis of the collected information as presented by the facility. The report identified the Maple Lane unit experienced, "Three different residents with episodes of vomiting without complications", however added there was, "No patterns noted among residents and staff" despite the residents being on the same unit, in adjacent rooms, and

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having the same symptoms on 9/7/15, 9/13/15, and 9/20/15.

During interview on 10/20/15, at 1:05 p.m. registered nurse (RN)-A and the director of nursing (DON) stated RN-A was responsible for the collection and analysis of the infection data. The data is reviewed by RN-A, an analysis is typed up and attached to the data (i.e. September 2015 infections report) and it is discussed at the monthly Quality Assurance (QA) meetings. RN-A stated no tracking or trending was completed of resident symptoms, date they began and ceased. The organism(s) were tracked on the flowsheet's provided, and no further documentation was identified besides what was provided to the surveyors as their infection control program.

A facility policy on the infection control program was requested, but none was provided.

ANTIBIOTIC STEWARDSHIP:

An undated facility June 2015 Infections Report identified R2, whom resided on the Pine Lane unit, completed a "third round of ABT [antibiotic] after having positive recheck UA/UC [urinary analysis / urinary culture]." The report identified the, "Final recheck was negative with no significant growth." However, the report did not identify any signs or symptoms R29 was experiencing to warrant a repeat urine screening or antibiotic treatment.

A Facility Event Summary Report dated 6/1/15 to 6/30/15, identified R29 had a "UTI identify [sic] that grew out e-coli [a bacteria] ... Started on Ceftin [an antibiotic] 250 mg BId [sic, twice a day]

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x 10 day [times 10 days] ... [R29] does not have symptoms of UTI..."

During interview on 10/20/15, at 1:09 p.m. RN-A stated it was up to the physician to determine if a repeat UA/UC should be obtained, "It's the physician decision", and only one of the physicians who see residents at the facility did not routinely order a follow-up urine screening. Further, RN-A stated most of the physicians do request a follow-up urine screening and some are treated with antibiotics despite the lack of symptoms.

LACK OF HAND HYGIENE DURING CARES:

During observation of morning cares on 10/14/15, at 7:59 a.m. nursing assistant (NA)-A completed perineal cares using gloved hands. NA-A assisted R24 to turn onto the left side in bed, and cleaned incontinent stool from R24's buttocks. With his soiled gloves NA-A proceeded to pull up R24's pants, adjust his shirt, and apply a foot brace to his left foot. He continued with his soiled gloves and removed the gait belt and placed it on the bed; unlocked R24's wheelchair brakes placing it next to the bed touching both handles of the chair. NA-A cleaned up the used supplies in the room, then removed his soiled gloves disposing of them in the trash. NA-A left R24's room without washing his hands or performing any further hand hygiene, and assisted another staff member with a transfer of a different resident.

During an interview on 10/14/15, at 8:49 a.m. NA-A stated he should have removed the soiled gloves after performing perineal care, and should have washed his hands prior to leaving R24's

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room to help with another resident, "I know that. I was just nervous."

During observation of morning cares on 10/15/15, at 6:28 a.m. R31 was being assisted by nursing assistant (NA)-H with dressing. NA-H removed R31's incontinence pad with gloved hands, completed perineal cares and applied a new incontinence pad. NA-H removed her soiled gloves and assisted R31 to turn onto his side, placing a mechanical lift sling underneath of him. NA-H left the room and returned with a mechanical lift to transfer R31 from bed to his chair. NA-H did not wash her hands after removing her gloves which were used to complete perineal cares for R31. NA-H assisted R31 to the commons area in his wheelchair, returned to his room and cleaned up the used supplies from his morning cares. NA-H washed her hands after placing the soiled linens in the soiled utility closet.

When interviewed on 10/15/15, at 1:37 p.m. NA-H stated she should have washed her hands after removing her gloves when caring for R31.

During observation of wound care on 10/15/15, at 2:35 p.m. registered nurse (RN)-B applied a pair of disposable gloves and assisted R14 off a bedpan. RN-B completed perineal cares using her gloved hands, then removed the old dressing from R14's buttock. RN-B did not perform handwashing, or change her gloves after performing perineal care prior to removing the dressing from R14's buttock. RN-B stated the old dressing appeared to be completely soiled with feces, and the nursing assistants should have reported it. RN-B removed her soiled gloves, and

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applied new ones without washing her hands. RN-B proceeded to measure the wound on R14's buttock, and prepare a new dressing to be applied to the wound using her gloved hands. RN-B removed the gloves, and RN-B left the room to retrieve a different type of dressing which was applied to R14's buttock. RN-B did not wash her hands after removing her soiled gloves.

During interview on 10/15/15, at 3:04 p.m. RN-B stated she did not complete hand hygiene, including washing her hands, after removing her gloves, but should have.

A facility Dressing, Dry/Clean policy dated 2/2014, identified staff should use clean gloves to remove any soiled dressings, and wash their hands after removing any gloves.

During observation of morning cares on 10/14/15 at 8:10 a.m., nursing assistant (NA)-C provided perineal cares for R57 using gloved hands. Afterwards, NA-C took the used wash basin and cloth into the bathroom and removed her gloves. Without washing her hands, NA-C donned a new pair of gloves, and placed R57's stockings on his feet, followed by R57's shoes. NA-C entered the bathroom, rinsed R57's dentures, and, with the same gloved hands, held R57's dentures so R57 could insert them. While continuing to wear the same gloves, NA-C gave R57 his glasses, then bagged up soiled clothing, as well as the garbage, and placed a new liner in the trash can. After depositing the bagged items in the soiled utility area, NA-C returned to R57's room, with hands still unwashed.

In an interview on 10/14/15, at 8:28 a.m., NA-C stated she should wash her hands "before and

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F 441	Continued From page 92 after cares." NA-C stated she usually just "changes gloves" and that she uses "alcohol scrubs" to cleanse her hands. When interviewed on 10/16/2015 at 11:06 a.m., licensed practical nurse (LPN)-A said all staff had "training annually for infection control." LPN-A stated staff actually "have to demonstrate handwashing." LPN-A said handwashing was done "before and after" resident cares, after toileting, with any bodily fluid contact, "even if you wear gloves." When interviewed on 10/15/15, at 1:39 p.m. RN-C stated hand hygiene, including hand washing, should be performed after perineal care is provided, and after gloves are removed. When interviewed on 10/16/15, at 10:49 a.m. RN-A stated hand hygiene should be performed after perineal care, and anytime after gloves are removed. A facility Perineal Care policy dated 10/2010, identified staff should remove their gloves when completed, then wash and dry their hands. A facility Handwashing / Hand Hygiene policy dated 8/2014, identified staff should use an alcohol-based hand sanitizing rub or soap and water after direct contact with residents, before handling clean or soiled dressings, and after removing gloves. Further, the policy identified gloves were not to be used to replace hand washing.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520		11/30/15

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F 520	Continued From page 93 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility's quality assessment and assurance (QA&A) committee failed to develop, implement, and re-evaluate action plans to address and identify systematic concerns of inadequate staffing patterns to ensure residents were provided with care and services in accordance with their assessed needs, in the area of activities of daily living (ADLs), pressure ulcers, range of motion, restorative nursing, and infection	F 520	A: All residents found to be effected by deficiencies will be reviewed by the Administrator and Director of Nursing, on a weekly basis, to assure compliance. The cited areas will be reported in all upcoming Quality Councils. B: QA team will review, evaluate and, if needed, recommend improvement processes to ensure other residents are not affected by the same deficient practice.	

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F 520	Continued From page 94 control and facility staffing for 14 of 37 residents (R28, R53, R17, R24, R3, R29, R57, R35, R28, R14, R31, R2, R33, and R47) reviewed for compliance with quality of care, quality of life, nursing services and infection control regulations. This had the potential to affect all 47 residents in the facility. Findings include: The facility did not ensure staff followed the plan of care for 2 of 7 residents (R28 and R53) reviewed for activities of daily living (ADLs), 4 of 4 residents (R17, R24, R3, and R29) reviewed for range of motion (ROM), 3 of 4 residents (R57, R35, R28) reviewed for ambulation; 2 of 3 residents (R14, and R31) at risk for pressure ulcers, and for 1 of 3 residents (R2) reviewed for monitoring skin concerns. Refer to F282 The facility did not provide and consistently implement ambulation services to improve and/or maintain residents' ambulation abilities for 4 of 5 residents (R57, R35, R28 and R53) in the sample reviewed for restorative nursing services. Refer to F311. The facility did not provide bathing assistance for 6 of 7 residents (R17, R35, R57, R33, R47 and R24), who were dependent upon staff for bathing. Refer to F312. The facility did not monitor, assess, and implement and/ or revise interventions to prevent pressure ulcers from developing, and to ensure healing of current pressure ulcers for 2 of 2 residents (R53, R14) reviewed for pressure	F 520	C: Redistribute workload for the QMC position to allot more time for quality improvement and quality assurance. Case managers will be involved in monthly QA meetings to more quickly identify problem areas. Case managers will meet with rehab aids on weekly basis to discuss any changes in ADL performance. Nurse Staffing Coordinator will report to the QA committee on progress of open shifts filled. QA action plans will be developed, implemented, and re-evaluated for progress according to the regulations. Don will review with monthly CNA/Nurse meetings any items that they wish to bring forward to Quality Council. D: All percentage of completion audits will be presented to the Quality Council by use of the Quality Council Report Form to assist with QA actions and evaluations to ensure residents are provided with care and services in accordance with their assessed needs. Results will be monitored by the Administrator and Director of Nursing	

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ulcers. This resulted in actual harm for F53 who had recurring, multiple pressure ulcers. Refer to F314.

The facility had not consistently provide range of motion services for 4 of 4 residents (R17, R24, R3 and R29) in the sample reviewed for restorative nursing services.

The facility did not implement an infection control program to include consistent monitoring, trending and analysis of infections to reduce the transmission to other residents in the facility. In addition, the facility did not ensure handwashing was completed to reduce the potential spread of infection for 4 of 6 residents (R24, R31, R14, R57) whose cares were observed during the survey. Refer to F441.

The facility did not provide sufficient staffing to ensure the assessed needs and services were provided pressure ulcers, assistance with activities of daily living (ADL's), and restorative nursing. Even though lack of staffing concerns were expressed by family members and facility staff about resident cares and treatments were not being completed, or completed timely. Refer to F353.

During an interview on 10/20/15, at 9:49 a.m. the administrator, director of nursing (DON), and registered nurse (RN)-A discussed current topics of the facilities quality assurance (QA) committee. RN-A stated the QA committee had recently identified the following issues: staffing, falls, timely completion of clinical assessments, antipsychotic rate and appropriate antipsychotic diagnoses, and culture change. RN-A

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emphasized that "nearly all" of the issues in the facility, including bathing, restorative nursing, range of motion, pressure ulcers, and ADL's, were a result of the staffing issue at the facility. RN-A further stated, the only new admissions the facility accepted since September 1, 2015, were those residents "that had been in the facility in the past." In addition, RN-A stated, we don't want to keep taking admissions if we "don't have the staff to take care of them." RN-A also said, the "root cause" of most of our issues, "is staffing."

In continuing the interview, when asked about pressure ulcers, RN-A stated pressure ulcers have risen since the surveyors arrived on site. RN-A further stated, "we knew about a couple" of the pressure ulcers. When asked if the the QA committee determined an action plan was needed, the DON stated, "If we had a comprehensive assessment," that certainly would have made it easier.

Although the facility faced care area issues with pressure ulcers, restorative nursing, range of motion, infection control, and timely completion of ADLs, the facility rationalized the concerns were all related to inadequate staffing. The facility failed to initiate action plans in the quality assurance process to address these concerns, independent of staffing.

Review of the facility policy Quality Council: Quality Assessment and Assurance Committee, review/revised date 2010, identified the purpose, "Monitor the provision of care and services systematically by leadership." The policy included, "There is an established Quality Council that assumes responsibility for services related to

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the quality of care, quality of life, customer satisfaction, and regulatory compliance and related performance improvement."

The procedure indicated under #1, "The Quality Council monitors and systematically evaluates care and services to identify opportunities for improvement, determine the potential root cause, develops and/or approves action plans to create improvement and evaluates the effectiveness of such action plans."

The procedure indicated under #6, "Through tracking and trending of facility functioning, as well as relevant comparisons when available, the Quality Council addresses at a minimum:

a) Regulatory compliance,
b) Resident incident and accidents,
c) Resident and or family complaints,
d) Infection Control,
e) Medications and pharmacy services,
f) Customer satisfaction,
g) Clinical Reimbursement and Compliance Review, and
h) CMS Quality Measures/Indicators."

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BENEDICTINE LIVING COMMUNITY OF NEW LONDON	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS - 2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Living Community of New London was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

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

Electronically Signed | 11/18/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245360	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE LIVING COMMUNITY OF NEW LONDON	**100 GLEN OAKS DRIVE** **NEW LONDON, MN 56273**

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K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Benedictine Living Community of New London is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1964 and was determined to be of Type II(000) construction. In 1993 and addition was added to the south of the Service Wing that was determined to be of Type II(000) construction. In 1996 and addition was added to the north of the Service Wing that was determined to be of Type II(000) construction. In 1999 and addition was added to the south of the 1993 addition that was determined to be of Type II(000) construction. Because the original building and the 3 additions are of the same type construction the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 The building is fully protected by a fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 52 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 25 (98) could allow system being place out of service causing a decrease in the fire protection system	K 056	a.Maintenance staff has been educated regarding the necessity to not have 2 different types of sprinkler heads in the same compartment. Maintenance will inspect all compartments to ensure sprinkler heads are in compliance with K56 as it relates to similar sprinkler heads.	11/25/15

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K 056	Continued From page 3 capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 1:30 PM on 10/16/2015, observations have revealed that there are two different types of sprinkler head mixed in the same compartment, there are 2 quick response heads mixed in with standard type heads located in the entrance of the Physical Therapy corridor. This deficient practice was confirmed by the Administrator (JI) at the time of discovery.	K 056	b.Corrected on or before November 11/25/15. c.Responsibility of Maintenance Director to correct.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 47 residents.	K 144	a.Maintenance staff has been educated regarding the importance of maintaining monthly documentation for generator testing, which includes minimum Load test. Maintenance will maintain monthly Generator test documentation and will be audited monthly for 3 months, then	11/25/15

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K 144	Continued From page 4 Findings include: On facility tour between 9:30 AM and 1:30 PM on 10/16/2015, documentation review of the monthly inspection logs No documentation could be located for the emergency generator of the monthly operational inspections. This deficient practice was confirmed by the Administrator (JI) at the time of discovery.	K 144	quarterly and reported on a quarterly basis to the Quality Council. b.Corrected on or before 11/25/15. c.Responsibility of Maintenance Director to correct.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
November 9, 2015

Mr. James Ingersoll, Administrator
Benedictine Living Community Of New London
100 Glen Oaks Drive
New London, Minnes 56273

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5360027

Dear Mr. Ingersoll:

The above facility was surveyed on October 12, 2015 through October 20, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5360015. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00314	A. BUILDING: _____ B. WING _____	10/20/2015

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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 October 12-20th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. In addition, an investigation of complaint H5360015 was completed which was substantiated. Correction orders were issued at State Licensing Rule 4658.0085 A-E 0265. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St. Cloud, MN 56301.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by:	2 255		

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2 255	Continued From page 3 Based on observation, interview and document review, the facility's quality assessment and assurance (QA&A) committee failed to develop, implement, and re-evaluate action plans to address and identify systematic concerns of inadequate staffing patterns to ensure residents were provided with care and services in accordance with their assessed needs, in the area of activities of daily living (ADLs), pressure ulcers, range of motion, restorative nursing, and infection control and facility staffing for 14 of 37 residents (R28, R53, R17, R24, R3, R29, R57, R35, R28, R14, R31, R2, R33, and R47) reviewed for compliance with quality of care, quality of life, nursing services and infection control regulations. This had the potential to affect all 47 residents in the facility. Findings include: The facility did not ensure staff followed the plan of care for 2 of 7 residents (R28 and R53) reviewed for activities of daily living (ADLs), 4 of 4 residents (R17, R24, R3, and R29) reviewed for range of motion (ROM), 3 of 4 residents (R57, R35, R28) reviewed for ambulation; 2 of 3 residents (R14, and R31) at risk for pressure ulcers, and for 1 of 3 residents (R2) reviewed for monitoring skin concerns. Refer to F282 The facility did not provide and consistently implement ambulation services to improve and/or maintain residents' ambulation abilities for 4 of 5 residents (R57, R35, R28 and R53) in the sample reviewed for restorative nursing services. Refer to F311. The facility did not provide bathing assistance for	2 255		

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2 255	Continued From page 4 6 of 7 residents (R17, R35, R57, R33, R47 and R24), who were dependent upon staff for bathing. Refer to F312. The facility did not monitor, assess, and implement and/ or revise interventions to prevent pressure ulcers from developing, and to ensure healing of current pressure ulcers for 2 of 2 residents (R53, R14) reviewed for pressure ulcers. This resulted in actual harm for F53 who had recurring, multiple pressure ulcers. Refer to F314. The facility had not consistently provide range of motion services for 4 of 4 residents (R17, R24, R3 and R29) in the sample reviewed for restorative nursing services. The facility did not implement an infection control program to include consistent monitoring, trending and analysis of infections to reduce the transmission to other residents in the facility. In addition, the facility did not ensure handwashing was completed to reduce the potential spread of infection for 4 of 6 residents (R24, R31, R14, R57) whose cares were observed during the survey. Refer to F441. The facility did not provide sufficient staffing to ensure the assessed needs and services were provided pressure ulcers, assistance with activities of daily living (ADL's), and restorative nursing. Even though lack of staffing concerns were expressed by family members and facility staff about resident cares and treatments were not being completed, or completed timely. Refer to F353.	2 255		

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2 255	Continued From page 5 During an interview on 10/20/15, at 9:49 a.m. the administrator, director of nursing (DON), and registered nurse (RN)-A discussed current topics of the facilities quality assurance (QA) committee. RN-A stated the QA committee had recently identified the following issues: staffing, falls, timely completion of clinical assessments, antipsychotic rate and appropriate antipsychotic diagnoses, and culture change. RN-A emphasized that "nearly all" of the issues in the facility, including bathing, restorative nursing, range of motion, pressure ulcers, and ADL's, were a result of the staffing issue at the facility. RN-A further stated, the only new admissions the facility accepted since September 1, 2015, were those residents "that had been in the facility in the past." In addition, RN-A stated, we don't want to keep taking admissions if we "don't have the staff to take care of them." RN-A also said, the "root cause" of most of our issues, "is staffing." In continuing the interview, when asked about pressure ulcers, RN-A stated pressure ulcers have risen since the surveyors arrived on site. RN-A further stated, "we knew about a couple" of the pressure ulcers. When asked if the the QA committee determined an action plan was needed, the DON stated, "If we had a comprehensive assessment," that certainly would have made it easier. Although the facility faced care area issues with pressure ulcers, restorative nursing, range of motion, infection control, and timely completion of ADLs, the facility rationalized the concerns were all related to inadequate staffing. The facility failed to initiate action plans in the quality assurance process to address these concerns, independent of staffing.	2 255		

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2 255	Continued From page 6 Review of the facility policy Quality Council: Quality Assessment and Assurance Committee, review/revised date 2010, identified the purpose, "Monitor the provision of care and services systematically by leadership." The policy included, "There is an established Quality Council that assumes responsibility for services related to the quality of care, quality of life, customer satisfaction, and regulatory compliance and related performance improvement." The procedure indicated under #1, "The Quality Council monitors and systematically evaluates care and services to identify opportunities for improvement, determine the potential root cause, develops and/or approves action plans to create improvement and evaluates the effectiveness of such action plans." The procedure indicated under #6, "Through tracking and trending of facility functioning, as well as relevant comparisons when available, the Quality Council addresses at a minimum: a) Regulatory compliance, b) Resident incident and accidents, c) Resident and or family complaints, d) Infection Control, e) Medications and pharmacy services, f) Customer satisfaction, g) Clinical Reimbursement and Compliance Review, and h) CMS Quality Measures/Indicators." SUGGESTED METHOD OF CORRECTION: The administrator could work with the DON or designee, medical director, and governing body to update polices and procedures, identify issues and develop improvement plans. The	2 255		

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2 255	Continued From page 7 administrator and or designee could audit cares. In addition, the quality assurance committee could develop, implent, and re-evaluate action plans to address identified concerns in regards to activities of daily living, pressure ulcers, range of motion, restorative nursing, urinary incontinence, non-pressure related skin conditions, and infection control. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
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 physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		

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2 265	Continued From page 8 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 interview and document review, the facility failed to notify residents' families in a timely manner for 1 of 1 residents (R2) with an elevated laboratory value that needed physician involvement and for 1 of 1 residents (R55) who was administered another resident's medications in error. Findings include: R2's significant change Minimum Data Set (MDS) dated 9/1/15, identified R2 had severe cognitive impairment, and had long term use of anticoagulant medication (used to thin the blood). R2's physician orders dated 10/14/15, identified R2 was prescribed coumadin, a medication to prevent strokes by thinning the blood which is monitored with a laboratory value called an international normalized ratio (INR). R2's fax communication from the physician dated 8/5/15, identified R2's INR goal was "2.0 - 3.0", but her most recent value was "7.9", more than twice the INR goal for R2. Further, the physician wrote an order, "Adjust coumadin to: Hold 8/5/15; Vitamin K [medication used to reverse the blood	2 265		

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thinning effects from coumadin] 2.5 mg [milligrams] p.o. [by mouth] today."

R2's medical record was reviewed, there was no indication R2's family had been notified of R2's elevated INR which required a physician involvement and a medication to correct the adverse effect of the coumadin, with a high INR.

During interview on 10/19/15, at 1:59 p.m. registered nurse (RN)-A stated when an INR is "significantly outside" of their established goal range and the resident requires Vitamin K, the family "should be notified." Further, R2's family "should have been notified" since her INR was over 3.5, and nursing staff should be documenting the notification in R2's progress notes.

When interviewed on 10/20/15, at 8:35 a.m. RN-C stated the family should be notified of all INR results for residents, not just when they are significantly out of range. R2's family is very involved with her care, and they should have "definitely" been notified of R2's increased INR value which required treatment.

A facility Change in a Resident's Condition or Status policy dated 9/2013, identified, "...the Nurse Supervisor/Charge Nurse will notify the resident's family or representative [sponsor] when ... There is a significant change in the resident's physical, mental, or psychosocial status

R55's quarterly Minimum Data Set (MDS) dated 8/19/15, identified R55 had severe cognitive impairment.

During an interview on 10/13/2015, at 10:24 a.m. family member (FM)-A stated she upset regarding

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2 265	Continued From page 10	2 265		

not being notified of a medication error involving R55 in a timely manner. R55 was given the wrong medication by staff on 5/2/15, but FM-A was not notified of the error until two days later on 5/4/15 when she had "an incidental meeting" with R55's nurse manager.

R55's nursing progress notes dated 5/2/15 to 5/4/15, identified the following:
> 5/2/15 - "Resident pleasant this shift with no negative behaviors noted. Med error performed by TMA, resident was given [another resident's] 2000 [8 p.m.] medications instead of her own. Passed on to monitor resident throughout the night for any adverse effects to medications. MD faxed. Supervisor notified. No adverse effects noted thus far."
> 5/3/2015 - "Res [resident] has been in a pleasant mood this shift. No SE [side effects] noted from med error from last evening."
> 5/4/2015 - "Res alert this shift w/occ [occasional] muttering noted. Appetite fair, eating 75% [percent] of breakfast, did feed self but needed occ ques [sic] to eat. Fluids enc [encouraged]. No nausea voiced."
> 5/4/2015 - "Drt. [daughter] [of R57] notified of med error over the weekend. She asked for a list of the meds that were given to her incorrectly."
The family was notified 2 days after the incident occurred.

R55's medical record was reviewed and lacked any evidence FM-A had been notified of the medication error prior to 5/4/15.

During an interview on 10/15/2015, at 8:48 a.m. registered nurse (RN)-C stated she had been working when the error was reported on 5/2/15. RN-C notified the supervisor of the error, and faxed the physician to update him, but added she

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2 265	Continued From page 11 did not notify R55's FM-A about it. RN-C stated she was aware FM-A was "very involved" in R55's care, shrugged her shoulders and stated, "I think [FM-A] should have been notified sooner." When interviewed on 10/16/2015, at 10:09 a.m. the social worker (SW) stated "for any little changes" in regard to R55's care, staff know to give FM-A notification adding FM-A should have been notified of the medication error, "Without question, [FM-A] should have been notified." During an interview on 10/16/2015, at 11:56 a.m. the director of nursing (DON) stated since the error occurred, the facility revised its policy to include "timely notification or update of the [resident's] family." Further, the DON stated FM-A should have been "notified right away" after R55 was given the wrong medications. A facility Monitoring Resident Post Medication Error Involving Administration of Incorrect Medications policy updated 6/1/2015, identified, "All sections of the 'Medication Error Report Form for Resident Given incorrect Medication' must be completed as soon as possible; this includes notification of physician and family." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures, conduct audits related to Notification of Change in Resident Health to ensure proper notification is conducted to the appropriate party when there is a change in health status. The director of nursing or designee could develop ensure staff training is conducted on an ongoing basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		

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2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure direct-care staff received/Alzheimer's training; and further, that residents and/or interested family were provided information regarding: the Alzheimer's training staff received, who received training, how often,	2 302		

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and a description of the training provided. This had the potential to affect all current residents of the facility and their families.

Findings include:

A review of staff participant list for the "Dementia Refresher" course, undated, included 65 staff on the roster. Of the 65 listed, 18 staff were identified as having completed the training, as of January 1, 2015. The facility was unable to provide a listing of staff who completed dementia training prior to January 1, 2015.

Review of "Brainz Staffing Agreement," between the facility and contract staff agency, signed 9/14/2015, indicated the agency would provide documentation of education and training [of agency staff.] There was no indication in the agreement detailing what education and training agency staff would have, nor indication if agency staff specifically had Alzheimer's training.

In an interview on 10/20/2015 at 9:05 a.m., the administrator stated he was "unable to verify" pool agency staff, currently deployed in the facility, had the state-required Alzheimer's training. The administrator also stated "we need to ensure our new staff" have the dementia training "before they hit the floor." The administrator also said he did not know the facility had to provide to residents information about what dementia training staff received. The administrator said right now this information "was not given to prospective residents."

In an interview on 10/20/2015 at 9:47 a.m., registered nurse (RN)-A stated the facility utilized a computer-based delivery method to complete the Alzheimer's training, and as of January 1,

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2 302	Continued From page 14 2015, a new provider was used. RN-A provided a roster of staff who completed training since January 1st, but could not easily identify staff who did not complete training. RN-A acknowledged that only "some staff" have completed the require Alzheimer's/dementia training; "many staff have not." In continuing the interview, RN-A believed the information about the Alzheimer's training, the frequency, the description, etc, was only given to residents "upon request," and not aware it needed be given to all residents. RN-A stated the Alzheimer's/dementia training info was "not" part of the admission information provided to residents, "but it will be." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its process to ensure: Alzheimer's training is timely completed by both facility and contracted nursing staff; and residents and interested others are made aware that dementia training is provided to staff, who received training, the frequency of training, and a description of the training topics. 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	2 560		

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2 560	Continued From page 15 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 the comprehensive care plan based on assessment for 1 of 4 residents (R56) who utilized bilateral quarter side rails. Findings include: R56's initial Minimum Data Set (MDS), dated 9/22/2015, indicated R56 was cognitively intact, required extensive assistance with bed mobility, and activities of daily living. During the initial facility tour on 10/12/2015 at 1:19 p.m., R56 was observed to have bilateral quarter side rails on his bed. During an interview on 10/14/2015 at 1:45 p.m. R56 stated he used the side rails and "it necessary to have rail up" to aid in turning. R56's initial Siderail Assessment completed on 09/08/2015 indicated there was no need for the side rails. The facility Side Rail Assessment form dated 09/29/2015 indicated "Therapy request res[resident] have side rails to assist with sitting up in bed and transfers in out of bed and turning bed. Res is alert and oriented." Review of R56's care plan, last updated on 09/29/2015 did not identify that R56 utilized any	2 560		

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2 560	Continued From page 16 side rails for bed mobility, even though R56 assessment indicated he needed them. During interview on 10/19/2015 2:31 p.m. RN-A stated the side rails should have been addressed on the care plan and the nursing assistant care sheets, which was reviewed with RN-A at this time. The side rails were missing on the care plan and the nursing assistant care sheets for R56. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan development. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan development. The quality assessment and assurance committee could perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff followed	2 565		

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2 565	Continued From page 17 the plan of care for 2 of 7 residents (R28 and R53) reviewed for activities of daily living (ADLs), 4 of 4 residents (R17, R24, R3, and R29) reviewed for range of motion (ROM), 3 of 4 residents (R57, R35, R28) reviewed for ambulation; 2 of 3 residents (R14, and R31) at risk for pressure ulcers, and for 1 of 3 residents (R2) reviewed for monitoring skin concerns. Findings include: ADL's R28's 5-day Minimum Data Set (MDS) dated 8/26/15, identified R28 had severe cognitive impairment, and required extensive assistance to complete his ADLs. R28's care plan dated 10/9/15, identified an intervention of, "Ambulate to/from meals DAT [distance as tolerated] as he will allow with ext [extensive] 2A [assist of two]; follow behind w/ [with] w/c [wheelchair]." During observation of morning care on 10/14/15, at 9:20 a.m. R28 was assisted with dressing and toileting by nursing assistant (NA)-C, then seated in his wheelchair using a mechanical lift. R28 started to self propel out of his room into the hallway, when an unidentified staff member approached him and pushed him down to the breakfast meal in his wheelchair. No offer or attempt to ambulate R28 was provided as directed by the care plan. When interviewed on 10/16/15, at 11:28 a.m. restorative aide (RA)-A stated R28 was able to ambulate well using a walker for short distances, and was supposed to be walked by the nursing assistants to meals as directed by his care plan.	2 565		

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R53's quarterly MDS dated 9/16/15, identified R53 had moderate cognitive impairment, required extensive assistance for bed mobility, toilet use, and transferring, and had functional limitations in range of motion (ROM) with bilateral impairment to the lower extremities.

R53's care plan dated 9/16/15, identified an intervention of, "Staff offer to walk to and from BR [bathroom] as he is able and in halls per his wishes with walker and w/c [wheelchair] to follow." An undated Glenoaks Care Center-Maple 1 nursing assistant care sheet directed staff to, "Amb [ambulate] to/from meals DAT [distance as tolerated] w/ [with] walker et [and] w/c."

During an interview on 10/16/15, at 2:35 p.m., restorative aide (RA)-B stated R53 had a restorative program since 6/17/15 for ambulation. RA-B stated, "Therapy wanted me to walk him. He's supposed to walk every day. Sometimes he doesn't want to walk but will always do his pull ups." RA-B also stated, "I try to walk him every day but I get pulled to work on the floor. With the shortage of staffing, it doesn ' t' get done."

During an interview on 10/19/15, at 11:59 a.m., registered nurse (RN)-A reviewed the Point of Care documentation in R53's electronic medical record, and stated, "The last time [R53] was walked in his room and in the hallway [by nursing assistants] was on 9/14/15.

ROM

R17's diagnoses, as identified on the care plan

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revised 9/2/2015, included cerebrovascular disease, hemiplegia and hemiparesis. The annual MDS, dated 8/24/2015, indicated R17 required extensive assistance with most ADLs, including bed mobility and transfers. The MDS indicated R17 was cognitively intact.

R17's care plan, updated 9/2/2015, identified mobility as a care area, and directed a restorative nursing program. R17's program included an "exercise group," " ROM (range of motion)" to upper and lower extremities, and direction to "monitor for change" in ability to participate in group exercises and changes in assist with activities of daily living.

In an interview on 10/16/2015 at 9:41 a.m., registered nurse (RN)-A stated the "nurse managers" were in charge of the restorative programs, that they reviewed "their own resident" and "should be monitoring progress, as well if the programs "are getting done or note." RN-A said she "did not know" if the programs were getting done consistently. RN-A stated there was one primary restorative aide, and her back up is leaving the facility, right now have" not found someone who wants to step in."

In an interview on 10/16/2015 at 11:32 a.m., restorative aide (RA)-B stated she is supposed to see R17 "three times a week" for his restorative program, which included his upper and lower extremities. RA-B acknowledged R17 was not consistently receiving restorative services.

R24's annual Minimum Data Set (MDS) dated 7/22/15, identified R24 had intact cognition, required extensive assistance of two staff for bed mobility and transferring, and had functional

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limitations in range of motion (ROM) with bilateral impairment to upper and lower extremities.

R24's care plan, dated 10/11/15, identified R24 had impaired functional range of motion with contractures to all extremities related to diagnosis, and included a goal to maintain the ability to bear weight for transfers and to feed himself. R24's care plan included providing massage to neck prior to starting range of motion, passive range of motion (PROM) to left upper extremity, active assistive range of motion (AAROM) to right upper extremity, and bilateral lower extremity exercises with weights, knee extension, and hamstring curls.

R24's Restorative Flowsheets dated 7/1/15-10/20/15, identified R24's restorative program had been documented as completed as follows:

> July 2015 10 of 14 opportunities
> August 2015 6 of 13 opportunities
> September 2015 5 of 13 opportunities
> October 2015 1 of 8 opportunities

During an interview on 10/16/15, at 7:59 a.m., restorative assistant (RA)-A stated R24 was scheduled to receive restorative program, three times a week, but this wasn't always getting done. RA-A stated, "We have been getting pulled more and more to work the floor, so we've been getting to this [restorative program] less and less. We try to do the best we can but with staffing, it's been tough. We are pretty short." RA-A stated only two staff were trained to do the restorative program so other staff did not do the program with residents. RA-A stated, "Residents get frustrated when their exercises and walking aren't done," and stated he had reported this to the previous

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BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 21 director of nursing (DON). R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 to have moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff for transfers. The MDS also identified R3 to have bilateral impairment to the lower extremities, with zero days receiving passive ROM. R3's care plan dated 9/30/15, identified R3 with a goal to maintain ankle ankle and foot passive range of motion (PROM) including dorsiflexion (toes upward), plantarflexion (toes downward) with 15 reps each foot, heel cord stretches (toes upward and hold 30 seconds, with three reps to each foot/ankle), up to three times weekly as he tolerates. Review of R3's Restorative Flowsheets dated 6/1/15 to 10/20/15, identified R3's received PROM 25 of 65 opportunities during this time frame. When interviewed on 10/16/15, at 8:07 a.m. restorative aide (RA)-A stated the provided restorative services are identified on the Restorative Flowsheet. The restorative programs are not being consistently completed as the restorative aides are pulled to the floor to help with cares due to being short staffed. RA-A is typically scheduled to work on restorative programs four days a week, but is consistently pulled away from them three of the four days. The nursing assistants (NA) are not trained, nor do they complete restorative programs. Further, RA-A stated these concerns had been reported to the former director of nursing (DON).	2 565		

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2 565	Continued From page 22 R29's quarterly Minimum Data Set (MDS) dated 8/29/15, identified R29 had long and short term memory problems, was totally dependent on staff for her ADLs, and had limitations in her ROM on both sides of her body. R29's care plan dated 9/4/15, identified R29 was "at moderate risk" of contractures, and had "limited" ROM to her bilateral shoulders. Further, the care plan identified an intervention of, "PROM up to 3 X [times] weekly per therapy recommendations." Review of the Restorative Flowsheet Records from 8/2015 to 10/15/15 identified that PROM was to be offered three times a week. The Restorative Flowsheet Records identified R29's received the following PROM: > July 2015 10 of 13 opportunities > August 2015 5 of 13 opportunities > September 2015 2 of 13 opportunities > October 2015 2 of 7 opportunities When interviewed on 10/16/15, at 7:59 a.m., restorative aide (RA)-A stated he had been getting pulled to the floor to do cares instead of restorative programs, so the restorative programs had been getting completed "less and less." Further, only two staff were trained to complete restorative programs. AMBULATION R57's diagnoses, as identified on physician's orders dated 9/16/2015, included hemiplegia and hemiparesis. The quarterly MDS, dated 9/10/2015, indicated R57 required extensive assistance with transferring, and activities of daily living. The MDS also indicated he had intact	2 565		

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2 565	Continued From page 23 cognition. During observation on 10/14/2015 at 7:45 a.m. nursing assistant (NA)-B assisted R57 with morning cares. R57 used a hemi walker (an assistive walking device) to move from the bed and transfer into his wheel chair, while NA-B used a gait belt to assist R57. In an interview on 10/15/15 at 2:15 p.m., R57 stated he participates in a walking program, but lately he was only getting assistance with walking, "once a day," with two nursing assistants. R57 stated the walks "do not happen on the weekend." A Therapy to Restorative Nursing Communication Form, dated 6/30/2015, indicated R57 was to ambulate with (R57) daily in hallway, using assistance of 1 with gait belt, and 1 to push the wheel chair behind. Walk the length of handrail, 1-3 times per day. A review of R57's Restorative Flowsheets from 7/1/2015 to 10/10/2015 indicated R57 had ambulated 39 out of 102 opportunities. In an interview on 10/16/2015 at 8:18 a.m., restorative aide (RA)-A stated that R57 had a restorative ambulation program to walk in the hallway, and also that R57 "was pretty persistent about getting his walking done." RA-A stated he "was getting pulled" to work on the floor, and the restorative programs were often missed and not completed on the weekends. R35's diagnoses, as identified on the care plan, updated 10/13/2015, included Parkinson's	2 565		

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2 565	Continued From page 24	2 565		

disease, weakness, and history of falling. The quarterly Minimum Data Set (MDS), dated 6/25/2015, indicated R35 required extensive assistance with transferring, bathing and most activities of daily living. The MDS also indicated R35 had intact cognition.

R35's care plan, updated 10/13/2015, identified mobility as a care area, and directed staff to "walk to and from meals with FWW &1A (4 wheeled walker and assist of 1), pull w/c (wheel chair) behind, distance as tolerated.

During observation on 10/19/2015 at 12:05 p.m., R35 was in her wheel prior to the start of lunch, and NA-G pushed R35 from her room into the dining area. NA-G did not offer to ambulate R35.

In an interview, on 10/19/2015 at 12:08 p.m., NA-G said she did not know R35 was on a walking program.

During an interview on 10/16/2015 at 11:32 a.m., rehabilitation aide (RA)-B stated R35 "had no formal restorative program," but that she was to be walked from her room to the dining room, as much as she could. RA-B stated R35 was not always a willing participant, and needed encouragement, but it was important for her to keep walking. RA-B was not sure where R35's walking was documented or if the program was consistently implemented for R35.

In an interview on 10/19/2015 at 3:01 p.m., registered nurse (RN)-B stated she did not know whether R35's walking program "was documented anywhere." RN-B also stated her walking program "is on the CNA care sheet", and that the nursing assistants "are supposed to document." RN-B added that "right now" the

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2 565	Continued From page 25 walking and restorative programs were not getting monitored, and "probably were not recorded." R28's 5-day MDS dated 8/26/15, indicated R28 had severe cognitive impairment, and required extensive assistance, was unable to walk in the room or corridor, used a wheelchair for mobility and had no episodes of rejecting cares. R28's care plan dated 10/9/15, directed staff to ambulate R28 to and from meals, as tolerated with extensive assistance. During observation of personal cares on 10/14/15, at 9:20 a.m. NA-C assisted R28 to transfer into his wheelchair. R28 then propelled himself in his wheelchair with his feet into the hallway. An unidentified staff walking by R28, offered to push him to the dining room for breakfast, which he accepted. Staff did not offer R28 to walk to his meal, as identified in his care plan. During interview on 10/16/15, at 11:28 a.m. restorative aide (RA)-A stated R28 was not on the restorative program, but staff were directed to walk him as directed on the care plan. RA-A stated R28 walked well with a walker for short distances. During interview on 10/16/15, at 12:01 p.m. NA-G stated R28 does not walk, and she was not aware nursing was supposed to be walking R28.	2 565		

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2 565	Continued From page 26 PRESSURE ULCER R14's annual Minimum Data Set (MDS) dated 9/8/15, identified R14 to be cognitively intact, require extensive assistance with bed mobility, transfers, toileting and was frequently incontinence of urine. R14's care plan dated 9/18/15, identified a risk for skin breakdown related to pressure, and was incontinence of urine. The care plan directed staff to turn and reposition (R14) every two hour, and to provide toileting on rising, every 1.5 hours when awake, every two hours at night, and as needed. On 10/13/15, at 3:42 p.m. R14 observed lying in bed, on her back. R14 stated she was not receiving the help for repositioning, and had an open area on her buttocks. R14 stated the wound nurse ordered turning every 1.5 hours, but she was lucky to get help once during the day and once at night. During continuous observation on 10/14/15, from 7:01 a.m. to 9:44 a.m. R14 was laying in bed in her room. R14 was not offered or provided with any toileting or incontinence cares for 2 hours and 43 minutes. When notified of the lack of toileting or incontinence care for R14 on 10/14/15, at 9:40 a.m. licensed practical nurse (LPN)-C stated R14 should have been assisted with toileting every two hours. When interviewed on 10/14/15, at 9:40 a.m. LPN-C stated R14 is to be turned, repositioned, and offered toileting every two hours, and it would not be acceptable to go from 7:01 a.m. to current time (9:40 a.m.) with no one offering (R14) to be toileted or repositioned.	2 565		

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2 565	Continued From page 27 On 10/14/15, at 9:44 a.m. LPN-C and NA-D entered R14's room, assisted R14 to turn to the right and placed pillow under left side. R14 was offered to assist in using the bathroom but R14 refused. When interviewed on 10/14/15, at 1:02 p.m. NA-C stated R14 would be repositioned if the bedpan was used, and believed repositioning should be offered every two hours. When interviewed on 10/14/15, at 1:46 p.m. RN-B stated R14 was frequently incontinent of bowel and bladder, and is to be offered toileting and repositioning. RN-B stated it would not be acceptable to go two hours and 45 minutes without offering toileting or repositioning, and it should be offered every hour. R31's quarterly MDS dated 9/9/15, indicated severe cognitive impairment required extensive assistance for bed mobility and was at risk for developing a pressure ulcer. R31's care plan dated 9/21/15, indicated R31 to be at risk for skin impairment with interventions including alternating air mattress on bed, cushion in wheelchair, heel boots on when in bed, and elevate feet on a pillow when in bed or recliner. During observation of morning care on 10/15/15, at 6:28 a.m. R31 did not have a pillow under R3's feet. On 10/16/15, at 9:54 a.m. R31 was in bed, with no pillow underneath the feet. When interviewed on 10/15/15, at 11:05 a.m. RN-C stated R31 was to have a pillow under the	2 565		

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2 565	Continued From page 28 feet when in bed to assist in preventing pressure ulcers. When interviewed on 10/16/15, at 9:58 a.m. NA-D and NA-C was unaware R31 should have a pillow underneath the feet when in bed. When interviewed on 10/16/15, at 10:02 a.m. RN-C stated (R31) was to have a pillow placed under the feet when in bed. When interviewed on 10/20/15, at 9:34 a.m. RN-C stated staff were informed of the cares required on the care sheets, and in the communication book for R31 to have pillows under his feet. When interviewed on 10/20/15, at 9:40 a.m. NA-C stated no pillow had been placed under R31's feet when he was assisted to bed after breakfast, and indicated she was not aware this was required. SKIN MONITORING R2's diagnoses, as identified on the significant change Minimum Data Set (MDS), dated 9/1/15, included long term (current) use of anticoagulants, and was severely cognitively impaired. R2's care plan, dated 9/14/15, identified skin as a focus and included, "At risk for bruising r/t [related to] Coumadin usage. Easily bruises and skin is thin and fragile and gets skin tears easily r/t bumping into things with her w/c [wheelchair]." The care plan directed staff to, "Monitor skin w [with]/daily cares and wkly [weekly] bath. Monitor for bruising r/t Coumadin use. Monitor for suspicious lesions and refer to MD PRN" [as	2 565		

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2 565	Continued From page 29	2 565		

needed].

On 10/12/15, at 7:04 a.m. R2 was observed to have a bruise on the top of her left hand.

On 10/14/15, at 7:55 a.m. R2 was observed in the dining room. The top of R2's left hand was black and blue in color with a bruise extending from her knuckles to the wrist, approximately 2.5 inches x 5 inches.

During an interview on 10/14/15, at 8:26 a.m. R2 stated she was not sure how she got the bruise on the top of her left hand. She may have "bumped into something." R2 knew she was on a blood thinner, and said this was why she bruised "easily."

When interviewed on 10/14/15, at 9:15 a.m. nursing assistant (NA-G) stated she saw the bruise on R2's hand on the morning of 10/12/15 when she came to work. NA-G further stated, "I did not tell anyone" and "assumed" R2's bruise was already reported.

During interview on 10/14/15, at 9:17 a.m. NA-H stated she saw the bruise on R2's hand at 6:00 a.m. on 10/12/15, also when NA-H came to work. NA-H said she asked R2 what the bruise was from, but R2 did not recall where the bruise came from. NA-H also said, "I did not report the bruise to anyone."

When interviewed on 10/14/15, at 9:28 a.m. licensed practical nurse (LPN)-B stated, she was "not aware" R2 had a bruise on the top of her left hand. LPN-B also stated she took care of R2 "yesterday" (10/13/15), too, but did not see the bruise on top of R2's hand. In addition, LPN-B also said "no one had reported" the bruise to me

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2 565	Continued From page 30 and the "should have." LPN-B then stated she would measure the bruise and place on the treatment sheet to monitor it daily. A progress note dated 10/14/15, at 12:59 p.m. indicated R2's bruise was, "A 6 cm x 13 cm bruise was noted on top of Lt [left] hand on the weekend, when asked what had happened stated, 'I bump my hand all the time on the faucet or the EZ stand, its nothing'. Bruise is starting to turn yellow around the edges. Will monitor q [every] day." Review of the Facility policies titled Care Planning - Interdisciplinary Team revision date 9/13, and Care Plans - Comprehensive revision date 9/10, did not address implementation of the care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 800	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	2 800		

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2 800	Continued From page 31 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficent staffing to ensure the assessed needs and services were provided for 2 of 2 residents (R53 and R14) reviewed for pressure ulcers, which resulted in actual harm for R53. In addition, the facility failed to provide adequate staffing to ensure residents received required assistance with activities of daily living (ADL's) for 13 of 47 (R47, R35, R17, R24, R57, R33, R28, R53, R40, R17, R12, R57, R33) residents who resided in the facility needing staff assistance for ADL's, and/or who voiced concerns of insufficient staffing. Further, the faciltiy did not provide restorative nursing, for 4 of 4 residents (R17, R24, R3 and R29) reviewed for range of motion. The lack of staffing had the potential to affect all 47 residents in the faciltiy. Additionally, for lack of staffing concerns were expressed by 1 of 3 family members (FM-A), and 5 of 22 employees, (LPN-A, NA-D, NA-I, NA-O, and housekeeping assistant (HK)-A, expressed concerns about resident cares and treatments not being completed, or completed timely. Findings include: The facility failed to following morning routine preferences for 1 of 1 residents (R24) reviewed	2 800		

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2 800	Continued From page 32	2 800		

for choices. Refer to F242 for additional information.

The facility failed to consistently provide or offer ambulation services for 4 of 5 residents (R35, R28, R53 and R57) reviewed for restorative nursing. Refer to F311 for additional information.

The facility failed to provide bathing assistance for 6 of 7 residents (R17, R35, R57, R33, R47 and R24), who were dependent upon staff for bathing. Refer to F312 for additional information.

The facility failed to implement interventions to minimize skin breakdown for 2 of 2 residents (R53 and R14) reviewed for pressure ulcers. This resulted in actual harm for R53, who had recurring pressure ulcers. Refer to F314 for further information.

The facility failed to provide timely assistance with toileting to promote urinary continence for 1 of 2 residents (R14) dependent upon staff for toileting assistance. Refer to F315 for further information.

The facility failed to consistently provide the necessary services to maintain range of motion for 4 of 4 residents (R17, R24, R3 and R29) reviewed in the sample. Refer to F318 for further information.

RESIDENT COMPLAINTS

R40's quarterly Minimum Data Set (MDS) dated 6/30/15, indicated the resident had no cognitive impairment, and required physical assistance with bathing and supervison of staff for dressing, grooming, and mobility.

During interview on 10/12/2015, at 5:07 p.m. R40

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stated the facility did not have a consistent bath aide, and she was supposed to be getting a bath twice a week, however, due to the lack of staffing, she did not recieve her bath when she was scheduled for it, and thought it had been about a week since she had recieved assistance with bathing.

R17's annual MDS dated 8/24/15, indicated the resident had no cognitive impairment, required extensive assistance for transferring, bed mobility, and most activities of daily living (ADLs).

During interview on 10/12/15, at 7:29 p.m. R17 stated he was supposed to get bathed twice a week, however, he does not always get his baths because there are, "Not enough people [staff] here" to assist with his bath. R17 stated, "It does make me upset that I don't get my bath."

R12's significant change MDS dated 9/9/15, indicated the resident had no cognitive impairment, and required extensive assistance for bed mobility, transferring, and most ADLs.

During interview on 10/12/15, at 6:50 p.m. R12 stated the facility needed more staff on all shifts, and she had soiled herself having to wait for assistance with toileting. R12 stated, "I don't like that," and stated waiting for help to the bathroom because they are short staffed, "Is something that shouldn't have to happen."

R57's quarterly MDS dated 9/10/15, indicated the resident had no cognitive impairment, and required extensive assistance with transferring, walking, and most ADLs.

During interview on 10/12/15, at 6:30 p.m. R57 stated he was, "Frustrated," because he was not

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2 800	Continued From page 34 receiving his scheduled bath because the facility did not have enough staff. FAMILY COMPLAINTS Family member (FM)-A during interview on 10/13/15, at 10:57 a.m. stated the facility is short staffed, and feels that many of the departments have cut back on staff. FM-A stated even housekeeping had cut back on staff, and her mothers wheelchair is often dirty because there is no staff to clean it. STAFF COMPLAINTS Licensed practical nurse (LPN)-A during interview on 10/13/15, at 3:29 p.m.stated the facility often used pool nursing agency staff in the mornings to cover shifts, and resident baths were not getting completed due to the lack of staffing. LPN-A stated bath aides were needed to work as NA's (nursing assistant) on the floor, therefore, there was no staff to complete resident baths. LPN-A also stated the restorative aides were often pulled to work on the floor when they should be assisting residents with their restorative program, however, the facility was short staffed so they needed to assist with resident cares, therefore, the restorative programs were not being completed for residents. NA-D during interview on 10/14/15, at 9:18 a.m. stated the facility did not currently have a bath aide, and it was difficult to complete resident baths. NA-D stated when there is a bath aide on the schedule, they, "Often get pulled to work the floor," to assist with resident cares because the facility does not have enough staff to provide the required resident cares.	2 800		

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2 800	Continued From page 35 NA-I during interview on 10/14/15, at 1:24 p.m. stated she, "Gets angry," when resident bathing does not get done, and had brought her concerns to the administration several times regarding the inability to complete resident cares related to short staffing. NA-A stated, "I know the turning, toileting, and repo [repositioning] are not getting done." NA-I stated breakfast also gets delayed because there was not enough staff to get the residents out of bed timely, and also basic grooming does not always get completed related to lack of staffing. Housekeeping assistant (HK)-A during interview on 10/14/15, at 1:46 p.m.stated housekeeping hours had been cut down, and there were concerns of not having enough staff and time to ensure all cleaning duties were being completed. HK-A stated housekeeping was not always able to ensure deep cleaning of rooms, including wiping down baseboards, and wiping down walls and furniture were being completed related to the lack of staffing. NA-O during interview on 10/19/15, at 3:12 p.m. stated R35 would be able to walk if staff would have time to walk her, however, the facility did not have enough staff to ensure the residents were being provided restorative care they had been assessed to recieve. Staffing Coordinator (SC)-A during interview on 10/14/15, at 2:40 p.m. stated she was aware the bath aide and the restorative nursing aide get reassigned to assist with resident cares, "Quite a bit." SC-A stated she was aware residents had voiced concerns to the facility they were not receiving their baths, and the facility was currently working on trying to train in two additional bath	2 800		

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2 800	Continued From page 36 aides. SC-A stated the facility had specific concerns with lack of staffing on the day shift (early morning), and the facility had been discussing solutions, and there is an ongoing request to present staff to assist with any open available hours. SC-A stated there were currently no changes related to taking admissions due to lack of staffing, and the facility was currently utilizing 4 different pool nursing staff agency's to work on the lack of staffing to provide the necessary resident cares. In an interview on 10/16/2015 at 12:02 p.m., the director of nursing (DON) stated they had been "doing a lot of interviewing" regarding staffing, and acknowledged that it was often difficult "to get residents up in the mornings." The DON acknowledged staffing was concern for the facility, and the facility recently had "a wage increase," and also had "sign on bonuses" and were offering "more scholarships" to draw people in to work. The DON also said they were offering "flexible scheduling" to accommodate staff, were looking to post a position for "rehab" [restorative nursing], and were also looking to have "more staff trained and cross trained" for both bathing and rehab. The DON openly stated the facility recognized "staffing is an issue." During an interview on 10/20/15, at 9:49 a.m. the administrator, director of nursing (DON), and registered nurse (RN)-A all identiifed they had concerns with staffing in the faciltiy and were trying to resolve these issues. SUGGESTED METHOD OF CORRECTION: The administer or desigee could review staffing	2 800		

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2 800	Continued From page 37 patterns and make adjustments to ensure each resident receives the needed assistance and care in a timely manner. In addition, the administrator or designee could review facility staffing patterns and develop ways to promote and recruit needed staff. 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 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 consistently monitor bruising for 1 of 1 residents (R2) who was identified at risk of bleeding, due to her medication regime. Findings include:	2 830		

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2 830	Continued From page 38 R2's significant change Minimum Data Set (MDS) dated 9/1/15, identified R2 had severe cognitive impairment, and had long term use of anticoagulant medication (used to thin the blood). R2's care plan dated 9/14/15, identified R2 was, "At risk for bruising r/t [related to] Coumadin usage. Easily bruises and skin is thin and fragile and gets skin tears easily r/t bumping into things with her w/c [wheelchair]." The care plan directed staff to, "Monitor skin w [with]/daily cares and wkly [weekly] bath. Monitor for bruising r/t Coumadin use. Monitor for suspicious lesions and refer to MD PRN" [as needed]. On 10/14/15, at 7:55 a.m. R2 was observed in the dining room. The top of R2's left hand was black and blue in color. The bruising extended from her knuckles to the wrist, approximately 2.5 inches x 5 inches. During an interview on 10/14/15, at 8:26 a.m. R2 stated she was not sure how she got the bruise on the top of her left hand. She stated she may have "bumped into something," was on a blood thinner, and this was why she bruised "easily." Review of the medical record identified R2's physician orders dated 10/14/15, identified R2 was prescribed coumadin, a medication to prevent strokes by thinning the blood which is monitored with a laboratory value called an international normalized ratio (INR). R2's fax communication from the physician dated 8/5/15, identified R2's INR goal was "2.0 - 3.0", but her most recent value was "7.9", more than twice the INR goal for R2. Further, the physician wrote an order, "Adjust coumadin to: Hold 8/5/15; Vitamin K [medication used to reverse the blood	2 830		

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2 830	Continued From page 39	2 830		

thinning effects from coumadin] 2.5 mg [milligrams] p.o. [by mouth] today."

When interviewed on 10/14/15, at 9:15 a.m. nursing assistant (NA-G) stated she saw the bruise on R2's hand on the morning of 10/12/15 (2 days ago) when she came to work. NA-G further stated, "I did not tell anyone" and "assumed" R2's bruise was already reported and being monitored.

During interview on 10/14/15, at 9:17 a.m. NA-H stated she first saw the bruise on R2's hand at 6:00 a.m. on 10/12/15. R2 did not recall where the bruise came from, nor did NA-H report it to the nurses, "I did not report the bruise to anyone."

When interviewed on 10/14/15, at 9:28 a.m. licensed practical nurse (LPN)-B stated, she was "not aware" R2 had a bruise on the top of her left hand. LPN-B took care of R2 "yesterday" (10/13/15), but did not see the bruise on top of R2's hand. LPN-B stated "no one had reported" the bruise to her, and if any of the nursing assistants noted the bruise, they "should have" reported the bruise. Further, LPN-B stated she would begin monitoring the bruise that day, on 10/14/15.

R2's medical record identified a physician communication fax dated 10/14/15, identified R2's INR (international normalized ratio) goal range was 2.0 to 3.0; and her INR was 5.7 on 10/14/15. The physician provided orders to hold all doses of coumadin for R2 and recheck her INR on 10/16/15.

During interview on 10/16/15, at 7:56 a.m. registered nurse (RN)-A said nursing assistants

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2 830	Continued From page 40 "are expected" to report new bruises to the nurse on duty. All NA's receive training (Expectations for Resident Cares) with orientation which tells them to report bruising and changes in skin condition, "My expectation is that nursing assistants would report all bruises when first observed." RN-A stated the bruising should have been monitored, and if there is a concern we need to contact the physician to get an INR level promptly to ensure the coumadin was in the therapeutic levels of (2.0 to 3.0) for this resident. Although R2 was on coumadin, and had a history of high INR levels, the facility was not consistently monitoring R2's bruising to ensure her INR levels remained in therapeutic range for R2. An undated Expectations for Resident Cares: Nursing Assistant Care Delivery Practice Demonstrated Appropriate Care training document identified, "Changes in resident condition are reported to licensed nurse, including but not limed to ... Changes in skin condition." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to implementing recommendations to prevent bruises and non-pressure related skin concerns. They could provide staff education, and the director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion	2 895		

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2 895	Continued From page 41 Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently provide range of motion services for 4 of 4 residents (R17, R24, R3 and R29) in the sample reviewed for restorative nursing services. Findings include: R17's annual Minimum Data Set (MDS) dated 8/24/15, identified R17 had intact cognition, and required extensive assistance with most activities of daily living (ADLs). R17's ADL Function and Rehabilitation Potential Care Area Assessment (CAA) dated 8/24/15, identified R17 had minimal movement of the left leg and no movement with the left hand, but was able to participate as desired with dressing and grooming. Further, the CAA identified R17 had worked with therapies in the past on several occasions. R17's care plan dated 9/2/15, identified R17 had	2 895		

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hemiplegia (paralysis of one side of the body) and cerebrovascular disease, and identified an intervention of a restorative nursing program. The program included attending an "exercise group", and, "ROM [range of motion]" to his upper and lower extremities. Further, the care plan directed staff to "monitor for change" in R17's ability to participate in group exercises and assistance to complete his ADLs.

R17's undated Restorative Nursing Program identified R17 should receive assisted active range of motion (AAROM), passive range of motion (PROM), and active range of motion (AROM) as follows:

Upper Body:
> AAROM to right (R) shoulder in flexion and abduction x (times) 10 repetitions (reps) each and;
> AAROM (R) elbow in flexion and extension x 10 reps and;
> AAROM (R) wrist in flexion and extension x 10 reps and;
> AAROM to (R) fingers: make and open fist and spread fingers apart for 10 reps and;
> PROM to left (L) shoulder in flexion and abduction x 10 reps each and;
> PROM to (L) elbow in flexion and extension x 10 reps and;
> PROM to (L) wrist in flexion and extension x 10 reps and;
> Passively stretch fingers and thumb of left hand to tolerance for 1 minute.

Lower Body:
> Passive hamstring stretches to bilateral (both sides) lower extremities for 3-5 minutes (could be done while performing upper body activities) and;
> AROM to AAROM (R) and (L) hop flexion x 10

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reps and;
> AROM to AAROM (R) and (L) knee extension and flexion (kicks) x 10 reps and;
> Heel cord stretches bilaterally for 1 min each.

During observation on 10/14/2015 at 8:22 a.m., NA-A and NA-B assisted R17 in his room to transfer from the toilet into his wheel chair using a mechanical lift. R17 was able to bear weight during the transfers, and hold on to the standing device using his right hand and arm.

R17's Restorative Flowsheets from 7/1/2015 to 10/10/2015 were reviewed and identified R17 received the following documented ambulation services:
> July 11 of 13 opportunities
> August 5 of 13 opportunities
> September 4 of 13 opportunities
> October 1 of 4 opportunities

In an interview on 10/16/2015 at 9:41 a.m., registered nurse (RN)-A stated the "nurse managers" were in charge of the restorative programs, that they reviewed "their own resident" and "should be monitoring progress, as well if the programs "are getting done or note." RN-A said she "did not know" if the programs were getting done consistently. RN-A stated there was one primary restorative aide, and her back up is leaving the facility, right now have "not found someone who wants to step in."

In an interview on 10/16/2015, at 11:32 a.m. restorative aide (RA)-B stated she was supposed to see R17 "three times a week" for his restorative program, which included his upper and lower extremities. RA-B said R17 had "arthritis on his weak knee," but denied that R17 has had changes or decline in his functional

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abilities. RA-B also said R17 usually participated in a daily "wellness program" run by the activity department staff. RA-B stated the past few months she had been working "more on the floor" because the facility was "short staffed", and R17 was not getting his restorative program completed as it should have been. Further, RA-B stated she knew restorative programs were important, but there "was nothing we can do."

During interview on 10/20/2015, at 9:18 a.m. the physical therapist (PT) stated the facility "should have a stronger follow up program after residents are discharged from therapy." In the past, "we had a weekly meeting with the RN in charge of the resident and the rehab aid" and "every resident would be discussed" at least monthly, and it "did not matter" whether a resident was getting therapy or was on a range of motion or walking program." The PT said it was a way for us to "catch things" before a resident lost functionality. The PT said restorative programs "were not" consistently completed. The PT said it was difficult to get and retain qualified staff, but "we still have to take care of the residents."

R24's annual Minimum Data Set (MDS) dated 7/22/15, identified R24 had intact cognition, required extensive assistance of two staff for bed mobility and transferring, and had functional limitations in range of motion (ROM) with bilateral impairment to upper and lower extremities.

R24's ADL Function and Rehabilitation Potential Care Area Assessment (CAA) dated 7/22/15, identified R24 had hip and knee flexion contractures and limited ROM to bilateral upper extremities. Further, R24 had a restorative plan to help maintain his limited functioning.

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2 895	Continued From page 45 R24's care plan dated 10/11/15, identified R24 had impaired functional range of motion with contractures to all extremities and included a goal to maintain the ability to bear weight for transfers and remain able to feed himself. The care plan identified interventions including for staff to provide massage to his neck prior to starting range of motion, passive range of motion (PROM) to left upper extremity, active assistive range of motion (AAROM) to right upper extremity, and bilateral lower extremity exercises with weights, knee extension, and hamstring curls. During an observation on 10/12/15, at 6:42 p.m., R24 was sitting in a motorized wheelchair. R24 leaned slightly to the left, head and neck tilted to the left, hands were close to his body and closed, and lower extremities were bent at the knees. R24 moved his right arm occasionally, with right elbow bent. During an interview on 10/13/15, at 3:44 p.m. R24 stated he was "supposed to work" with the restorative aides three times a week, but it was not consistently getting done "because they're short of help." R24 stated when that happens, "I do as much as I can, myself." R24's Restorative Flowsheet, dated 1/23/15, included, "Prior to ROM Start with Sombra [warming gel] massage to neck, stretch neck to decrease tone, then shoulders, elbow." Also included, staff were directed to provide PROM to left upper extremity, AAROM to right upper extremity, and 4# weights hip flexion, knee extension kicks, and hamstring curls with blue band 3 x 10 to bilateral lower extremities, on Monday, Wednesday and Friday.	2 895		

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2 895	Continued From page 46 R24's Restorative Flowsheets dated 7/1/15-10/20/15, identified R24's restorative program had been documented as completed as follows: > July 2015 10 of 14 opportunities > August 2015 6 of 13 opportunities > September 2015 5 of 13 opportunities > October 2015 1 of 8 opportunities During an interview on 10/14/15, at 2:26 p.m. physical therapist (PT)-A stated when residents complete therapy a maintenance program is recommended, and becomes a nursing restorative program. Nursing was responsible to monitor the program and make sure its completed. Further, PT-A stated R24 should be having his restorative ROM program completed as directed to maintain his strength. When interviewed on 10/16/15, at 7:59 a.m., restorative aide (RA)-A stated R24 should receive his restorative program three times a week,and the documentation on the Restorative Flowsheet was "accurate." RA-A stated he had been getting pulled to the floor to do cares instead of restorative programs, so they have been getting complete "less and less." Further, only two staff were trained to complete restorative programs, and the lack of the programs being completed was becoming upsetting to the residents, "Residents get frustrated when their exercises and walking aren't done." R3's annual Minimum Data Set (MDS) dated 9/19/15, identified R3 had moderate cognitive impairment, required extensive assistance of two staff for bed mobility, and total dependence of two staff for transfers. Further, the MDS identified R3 had bilateral mobility impairments to the lower	2 895		

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2 895	Continued From page 47	2 895		

extremities, and received no days of completed ROM.

R3's care plan dated 9/30/15, identified an intervention for staff to complete ankle and foot PROM including dorsiflexion, plantarflexion with 15 reps each foot, heel cord stretches, up to three times weekly as R3 tolerates.

R3's Restorative Flowsheet dated 1/23/15, identified an order for bilateral ankle and foot passive range of motion (PROM) including dorsiflexion (toes upward), plantarflexion (toes downward) 15 reps each foot. Heel cord stretches (toes upward and hold 30 seconds, with three reps to each foot/ankle), once a day Sunday, Tuesday, and Thursday up to three times a week.

R3's Restorative Flowsheets dated 6/1/15 - 10/20/15, identified the ordered PROM had been documented as completed as follows:

> June 2015 10 of 13 opportunities
> July 2015 9 of 13 opportunities
> August 2015 4 of 13 opportunities
> September 2015 1 of 13 opportunities
> October 2015 1 of 13 opportunities

When interviewed on 10/16/15, at 8:07 a.m. restorative aide (RA)-A stated the provided restorative services are identified on the Restorative Flowsheet. The restorative programs are not being consistently completed as the restorative aides are pulled to the floor to help with cares due to being short staffed. RA-A is typically scheduled to work on restorative programs four days a week, but is consistently pulled away from them three of the four days. The nursing assistants (NA) are not trained, nor

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2 895	Continued From page 48 do they complete restorative programs. Further, RA-A stated these concerns had been reported to the former director of nursing (DON). R29's quarterly Minimum Data Set (MDS) dated 8/29/15, identified R29 had long and short term memory problems, was totally dependent on staff for her ADLs, and had limitations in her ROM on both sides of her body. R29's care plan dated 9/4/15, identified R29 was "at moderate risk" of contractures, and had "limited" ROM to her bilateral shoulders. Further, the care plan identified an intervention of, "PROM up to 3 X [times] weekly per therapy recommendations." Review of the Restorative Flowsheet Records from 8/2015 to 10/15/15 identified that PROM was to be offered three times a week. The Restorative Flowsheet Records identified R29's received the following PROM: > July 2015 10 of 13 opportunities > August 2015 5 of 13 opportunities > September 2015 2 of 13 opportunities > October 2015 2 of 7 opportunities When interviewed on 10/16/15, at 7:59 a.m., restorative aide (RA)-A stated he had been getting pulled to the floor to do cares instead of restorative programs, so the restorative programs had been getting completed "less and less." Further, only two staff were trained to complete restorative programs, and the lack of the programs being completed was becoming upsetting to the residents. A facility Range of Motion Exercises policy dated 10/2010, identified staff should review the care plan and therapy recommendations prior to	2 895		

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2 895	Continued From page 49 completing ROM for each resident, and document the date and time, type of exercise completed, and how long the exercise was completed for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding range of motion and audit to ensure it is completed as directed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
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:	2 900		

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2 900	Continued From page 50 Based on observation, interview, and document review, the facility failed to monitor, assess, and implement and/ or revise interventions to prevent pressure ulcers from developing, and to ensure healing of current pressure ulcers for 2 of 2 residents (R53, R14) reviewed for pressure ulcers. This resulted in actual harm for F53 who had recurring, multiple pressure ulcers. Findings include: R53 sustained harm when he developed two stage 3 (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) pressure ulcers to the left and right heel, and a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer to the coccyx. The facility failed to monitor and comprehensively assess pressure ulcers as they developed; failed to notify the physician of the development of pressure ulcers to assure proper treatment; failed to obtain physician direction of treatments and to notify the physician when changes were made for treatment of the pressure ulcers; failed to perform ongoing assessment of the pressure ulcers; failed to assess the cause of each pressure ulcer as they developed; failed to evaluate and/ or modify pressure ulcer treatments; and failed to follow care planned interventions that were in place. R53's annual Minimum Data Set (MDS) dated 6/17/15, indicated R53 had severe cognitive impairment and had diagnosis including diabetes, peripheral vascular disease, and cerebrovascular accident (CVA) with hemiparesis (weakness on	2 900		

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one side of the body). The MDS also indicated R53 was at risk for developing pressure ulcers, but had no current pressure ulcers, and there were no pressures ulcers on the prior assessment.

R53's pressure ulcer Care Area Assessment (CAA) dated 6/17/15, indicated R53 was, "At risk for skin impairment and breakdown r/t [related to] s/p [status post] [following] CVA /TIA [transient ischemic attack] [mini stroke] w/ [with] (L) [left] hemiparesis, Alz [Alzheimer's] dementia, requiring assistance w/ all mobilities and toileting needs, bowel and bladder incont [incontinence], inability to communicate needs effectively at times, Dx [diagnosis] of DM [Diabetes Mellitus], PVD [peripheral vascular disease] w/Hx [history] of PU [pressure ulcer] to heels. Admitted [R53] to facility last year with (B) [bilateral] hamstring contractures which increases risk for pressure ulcers to heels/feet." R53's CAA also included, "No current skin issues. Heels intact." The CAA included interventions including; staff to reposition R53 every two hours, have the resident wear heel protectors while in bed, use of an alternating pressure mattress and a cushion in the wheelchair, and skin monitoring with daily cares.

R53's most recent quarterly MDS dated 9/16/15, indicated R53 continued to be at risk for pressure ulcers, and had one stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) that was not present on the prior MDS assessment, dated 6/17/15.

During an observation on 10/14/15, at 9:27 a.m., nursing assistant (NA)-B was assisting R53 with morning cares. R53 had a blue heel boot on the right heel, was wearing only a white sock on the

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2 900	Continued From page 52 left foot, and both heels were directly on the bed. R53's bottom sheet on the bed had numerous areas of drainage. NA-B removed the heel boot from the right heel, and there was a saturated dressing covering the lateral heel. NA-B then removed the sock from the left foot, which had a beefy red colored pressure ulcer approximately 2 cm, with 2 cm of surrounding tissue that had a pasty white color located on the medial left heel. NA-B stated she had never worked with R53, and she needed to find the nurse to have the pressure ulcer on the left heel covered. The blue heel boot for R53's left heel was observed laying in R53's recliner, and was not on his left heel. The blue heel boots were noted to be cloth foam boots which velcroed on the foot and leg, however, the heel was still touching the boot and pressure was not relieved from the heel (s)while wearing the blue boot. On 10/14/15, at 9:49 a.m. licensed practical nurse (LPN)-B entered R53's room per NA-B's request with dressings and a culturette. LPN-B removed the saturated dressing from the right heel and cultured the drainage on the right heel pressure ulcer. The right heel pressure ulcer was observed to be approximately 2-3 cm, beefy red, with surrounding tissue that had a pasty white color. LPN-B stated she worked with R53 daily, and knew about the pressure ulcer on the right heel however, she was not aware R53 had a pressure ulcer on the left heel also. LPN-B directed NA-C to summon registered nurse (RN)-C to assess R53's pressure ulcers on the heels. RN-C entered R53's room and stated she was aware R53 had a left heel pressure ulcer, but she was not aware it was open. RN-C observed R53's right heel pressure ulcer and identified it as a "stage 3" pressure ulcer, and stated the right heel appeared "Swollen" however RN-C did not	2 900		

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measure the right heel pressure ulcer. RN-C did measure the left heel pressure ulcer at that time and described it as, "4.5 centimeters [cm] in length with 2 cm open, and 3.7 [cm] width; with 1.2 c.m. actual open area." RN-C was unsure what stage the left heel pressure ulcer was.

During interview on 10/14/15, at 10:29 a.m. LPN-B stated the nursing assistants should be informing the licensed staff if they note any resident skin concerns however, LPN-B was not aware of R53's left heel pressure ulcer until this morning and stated, "No one had reported it." R53's Skin Risk Assessment with Braden Scale (a tool used to determine pressure ulcer risk) tool dated 6/11/15, identified the resident had a score of 18, which indicated R53 was at risk for pressure ulcer development. The assessment also indicated the resident had no current skin impairments/ pressure ulcers at the time of the assessment.

The next skin assessment completed for R53 was titled Observation Report, which included a summary under the Quarterly Review section dated 9/4/15, which indicated R53 continued to be at risk for skin breakdown and included; "Does have h/o [history of] pressure ulcer to L [left] heel, due to contractures to hamstrings and knees are bent putting pressure on the heels. Staff to apply (B) [bilateral] heel boots while in bed...Has had an open area to his lateral heel that appeared as a broken blister related to shoe slipping as he was propelling himself around in WC [wheelchair]." The assessment did not indicate which heel had the pressure ulcer, and the assessment identified interventions for staff to continue the repositioning plan of every 2 hours. Although the assessment indicated R53 had developed an "open area," there were no new interventions developed to

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relieve pressure from R53's heels such as floating the heels, or applying heel boots which would relieve pressure vs providing only protection to the heels.

The undated Glenoaks Care Center-Maple 1 nursing assistant care sheet, (a direction for staff on specific cares for residents) directed staff to place the blue heel boots on R53 while in bed and recliner. The care sheet lacked direction to staff regarding repositioning R53 every two hours as assessed, and there was no direction to staff to monitor R53's skin for pressure ulcers. The nursing assistant care sheet did not give any direction to staff regarding repositioning or indicate R53 had, or was at risk for, pressure ulcers.

R53's Resident Progress Notes from 8/13/15-10/14/15, identified the following:

8/13/15- R53, "Noted to have an open area on his (L) [left] lateral heel with is [sic] bath. States he is not aware if his shoes rub. Appears as blister that perhaps opened up and measures 1.1 x 1.1 cm [centimeters]. After his bath, foam dressing was applied. Instructed staff to leave his shoes off and grippy sock was applied. Nursing will monitor area." The note did not identify the stage, appearance of the wound bed, wound edges, surrounding skin, or the depth of the pressure ulcer. There was no indication if R53 had any drainage or discomfort from the pressure ulcer. When interviewed on 10/16/15, at 8:55 a.m., director of nursing (DON) stated the progress note on 8/13/15, should have identified the right heel had the pressure ulcer, not the left.

8/14/15- "Resident's heel is possibly from friction from his shoe constantly rubbing to the lateral

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part of his foot when he is self propelling in w/c [wheelchair]. This appears to be a Stage 2 PU [pressure ulcer]. Foam dressing is clean, dry, and intact. Will have staff not put shoes on either feet and only grippy socks." The note did not identify which heel had the pressure ulcer, however, the Resident progress note also indicated, "Checked (L) heel as well and was slightly red but blanchable." The note did not include a measurement of the red area on the left heel.

8/14/15- "MD updated on PU to (L) heel and left message for daughter." A corresponding fax to MD-A dated 8/14/15 included, "Resident has a stage 2 pressure ulcer to his (L) heel. Measuring 1.1 cm x 1.1 cm. Appears to be from rubbing on his shoes when he would self propel himself in the w/c [wheel chair]. Currently has foam dressing in place to keep wound clean and provide protection. He is going to have grippy socks on...until the wound is healed. Also will be having blue boots [heel protectors] on when he is in the recliner and in bed." The fax did not include any recommendations from MD-A, nor did the facility receive a response from MD-A verifying the information was received and reviewed. When interviewed on 10/16/15, at 8:55 a.m., DON again stated the pressure ulcer was actually on R53's right heel, and not the left.

8/20/15- "PU to left heel intact." The Progress Note did not include any measurements or description of the pressure ulcer. During interview on 10/16/15, at 8:55 a.m., DON again stated the pressure ulcer was actually on R53's right heel, and not the left.

8/21/15- "Continues to have an area on his (R) lateral heel. No drainage. No dressing was on this. Applied a foam dressing." The note did not

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identify the stage, measurements, appearance of the wound bed, wound edges, surrounding skin, or the depth of the pressure ulcer. There was no indication if R53 had any drainage or discomfort from the pressure ulcer.

The next Resident Progress Note or assessment regarding R53's pressure ulcer (s) was dated 9/3/15, 13 days later, which indicated R53's pressure ulcer was located on the (R) lateral heel, and measured 0.2 x 0.2 cm, with a small amount of serous drainage. The resident denied any pain, the area was cleansed with normal saline and a foam dressing was applied. The note also included, "Much improvement noted in the healing. ARea [sic] is showing good signs of healing." The note did not identify the stage of the pressure ulcer, appearance of the wound bed, wound edges, the skin surrounding, the wound, or the depth of the wound.

9/5/15- "Resident continues to have a small non-blanchable redden [sic] area to (R) lateral heel. Area measures 0.5 x 0.5 cm. Skin is intact. No drainage noted. Changed dressing to a Tegaderm Foam Adhesive dressing."

9/13/15- "Dressing changed to (R) heel d/t [due to] serous [bodily fluid typically pale yellow and transparent] drainage. Has loose dry skin on heel that hampered the adhesion of the dressing. Cleansed and dressed, pressure relieving boot reapplied." The note did not identify the stage, appearance of the wound bed, wound edges, surrounding skin, or the depth of the pressure ulcer. There was no indication if R53 had any discomfort from the pressure ulcer.

9/15/15- "Skin. No complications or concerns noted at this time. Skin is intact. No redness,

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pain, bruises, edema or sores noted." The heel pressure ulcer (s) were not addressed in this progress note, nor was there any indication the pressure ulcer had healed.

9/16/15- "Dressing changed on Rt [right] heel, no drainage noted on old dressing. Has a loose piece of skin covering wound, no signs of infection. New Tegaderm Foam adhesive applied." The note failed to include the size, the appearance of the wound, the skin surrounding the wound, and failed to note if the resident was experiencing any pain.

9/19/15- "Resident continues to have an area to (R) lateral heel. No drainage noted. There is a layer of skin that is hard and starting to come off. Left area OTA [open to air] and apply Eucerin cream to heels." The note failed to include the size, the appearance of the wound, the skin surrounding the wound, and failed to note if the resident was experiencing any pain.

9/22/15-"Continues with dry are [sic] to R [right] heel. Resident was wearing shoes when writer came on shift so tennis shoes removed." No further assessment of the pressure ulcer was documented.

9/23/15- Indicated R53's right foot was more swollen than the left, however, there was no assessment of the pressure ulcer to determine if there was healing, nor was there any indication the physician had been notified.

The next progress note regarding R53's pressure ulcer was 10/4/15, 11 days later which indicated, "On last rds [rounds] Sept 25th resident had a small dried callous area to (R) lateral heel and appeared it would fall off. Today staff alert writer

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2 900	Continued From page 58 that area was dark in color. Area measures 3.5 x 4 cm and is a thicker callous area, with a darker pigment almost black in color under the callous area. Area is not open, no drainage noted. Applied ABT [antibiotic] ointment to area and covered with Tegaderm Foam Adhesive." The note did not assess the ulcer to include the pressure ulcer stage, what the surrounding tissue was, or if R53 was experiencing pain. There was no corresponding assessment from the rounds which were completed on 9/25/15, which was referred to in the above assessment. 10/5/15- Indicated MD-A and R53's family were updated on right heel pressure ulcer and the current treatment staff was using was applying antibiotic ointment and covering with Tegaderm Foam Adhesive dressing. There was no indication what information was shared with MD-A, nor was there any changes to the treatment for R53's right heel pressure ulcer. 10/6/15- "R heel intact." 10/11/15- "Put new dressing to heel d/t not having one on there. Noted to have clear drainage on sock." The note failed to identify if they were referring to the right or left heel, and there was no further assessment and/ or description of the pressure ulcer. 10/13/15- "Dressing changed to R heel pressure ulcer d/t fully saturated. Serousanguinous [light yellow with small amounts of blood] fluid noted on dressing with some odor noted. Area cleansed with NS [normal saline], slough/dead skin noted to outer edges of wound, yellow slough noted to edges of wound 20%, beefy red in middle of wound 80%. Resident denied any pain to area. Treatment changed from check daily and change	2 900		

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2 900	Continued From page 59 every 7 days and PRN [as needed] to check every shift and change daily or PRN if more than 50% saturated. MD [MD-A] updated on status of wound. Awaiting reply." 10/14/15- 8:21 a.m. "Received fax order from [MD-A]... WC [Wound Ostomy and Continence Care] nurse referral made, and culture wound." 10/14/15- 10:50 a.m. (after observation was completed) "Resident's R heel wound remains open and draining Serousanguinous fluid. Stage III [3] at this time. Wound culture obtained and sent to lab per MD order. Resident also has a referral to WOC nurse. Resident noted to have L lateral heel PU Stage III with Wound bed measures 2.0 cm x 1.2 cm with 2.5 cm x 2.5 cm of divitalized skin around wound bed. Wound cleansed with NS, skin prep applied and covered with Tegaderm Foam dressing. Resident currently has an air mattress on bed, wears heel boots while in bed, only wears socks with no shoes, has been referred to WOC nurse, culture obtained on wound. MD [MD-A] to be updated on new PU to L heel. Potential for referral to Hagen Orthotics for protective AFO's [a plastic brace to support the foot and ankle in the proper position] for his heels while in bed d/t resident having have [sic] knee flexion contractures and when resident is in bed most pressure is put on his lateral heels. This current wound is a suspected deep tissue injury r/t this issue. Daughter also updated on this plan." Although on 10/14/15, at 9:49 a.m. R53 was observed to have pressure ulcers to both the right and left heel, there was no assessment or monitoring of R53's left heel pressure ulcer until 10/14/15, at 10:50 a.m. R53's care plan dated 9/16/15, identified R53 was	2 900		

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2 900	Continued From page 60	2 900		

at risk for skin impairment and had no current skin issues including, "Heels intact." The care plan directed staff to monitor skin with daily cares and bathing, place heel protectors on while in bed, turn and reposition the resident every two hours and as needed, lotion heels at bedtime, and to monitor for changes in condition/skin, and update the medical doctor (MD) as needed. Even though the facility documented R53 developed a pressure ulcer on the right heel on 8/13/15, the facility had not updated the care plan interventions to prevent additional pressure ulcers from developing, nor did the facility make any changes to ensure R53 did not continue to have pressure on his heels to ensure healing of the current pressure ulcers.

Review of R53's Treatment Flowsheet, dated 8/1/15-8/31/15, included, "Heel boots on while in bed, check for proper placement. Every shift." A undated, handwritten note was added which indicated to wear the heel boots in recliner also. Although the facility identified R53 had a pressure ulcer on his right heel on 8/13/15, there was no treatment ordered/ documented on the Treatment Flowsheet for August 2015, to the current heel pressure ulcer(s).

R53's Treatment Flowsheet, dated 9/1/15-9/30/15, included, "Check (R) heel dressing daily and change weekly on Thurs [Thursday] til healed. Once a Day on Thu [Thursday]." This was implemented on 9/3/15. An undated, handwritten note was added next to the order which included, "foam dressing" and "Tegaderm Foam Adhesive." R53's Treatment Flowsheet also included a handwritten note, implemented 9/19/15, which directed, "Check R heel q [every] NOC [night] notify if getting worse & make sure Eucerin is applied. The Treatment

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2 900	Continued From page 61 Flowsheet was initialed by staff to indicate the right heel pressure ulcer dressing was changed on 9/3/15, 9/5/15, 9/15/15, and was then left open to air on 9/19/15. Review of R53's medical record indicated the changing treatment to R53's pressure ulcer were nursing orders, not treatment orders obtained from the physician. R53's Standing Orders signed by the physician dated 4/26/14, directed staff, "May treat Stage I decubitus [pressure ulcer] per nursing order. Notify MD of stage 2 or greater ulcer for approval of treatment protocol." There is no indication the facility communicated with the physician and followed up to determine appropriate treatment for R53's worsening pressure ulcer until 10/13/15, nearly two months after the facility first noted the right heel pressure ulcer. R53's Physician Progress Note written by MD-A dated 9/25/15, indicated R53, "Complains today of left heel pain. It mainly happens at night time in the area where his healed ulcer is... There are no ulcers or openings on his left heel noted where he is having pain." During interview on 10/19/15, at 3:33 p.m. MD-A stated during R53's visit on 9/25/15, she had assessed R53's left heel pressure ulcer and it was not open, however, she did not assess the residents right heel pressure ulcer at this time, as she was not aware the resident had a pressure ulcer on the right heel. MD-A stated she was not aware of R53's right heel pressure ulcer until 10/14/15, when the facility notified her of the stage 3 pressure ulcer on the left heel. MD-A stated she had never received a fax in August (8/14/15) regarding R53 having a stage 2 pressure ulcer to his left heel.	2 900		

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2 900	Continued From page 62 During interview on 10/14/15, at 1:50 p.m. RN-C stated she was new to her role, and the RN who had the position prior to her had a binder she used to document wound cares, however, RN-C stated she had been unable to locate the documentation. RN-C stated she had not had any training regarding pressure ulcer and wound care, but she was planning on going with RN-B when she did wound rounds so RN-B could educate her on pressure ulcer treatment, assessment, and documentation. During a follow-up interview on 10/14/15, at 3:20 p.m. RN-C stated a call had been placed to the previous RN that held her position and was told there was no wound care binder; and any assessment and monitoring of resident pressure ulcers would be found in the Resident Nursing Progress Notes. During interview on 10/16/15, at 12:56 p.m. NA-G stated she occasionally assisted R53 with cares, and indicated staff were directed to put blue boots (heel protectors) on R53 to protect his heels when he was in bed or in the chair. R53's Resident Progress Note dated 10/18/15, indicated "Dressing changed to (B) [bilateral] heel this am d/t dressings coming off. Both heels were cleansed with NS, skin prep applied, and covered with Tegaderm Foam dressing and wrapped with kerlix [dressing applied to a wound] for security. Heel boots where [sic] both in place while in bed/recliner. No other skin issues to feet noted. Both wounds still noted to have eschar [thick, black, dry necrotic tissue] in place." An additional Resident Progress Note dated 10/18/15, indicated, "Res (resident) noted to have a stage 2 pressure ulcer to coccyx this am.	2 900		

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2 900	Continued From page 63 Very first layer of skin is off. Measure 1 cm x 2 cm, depth n/a. Wound bed red with no drainage. Res peri skin [skin surrounding wound] is blanchable." R53's Resident Progress Note dated 10/19/15, indicated, "Resident had a shower this a.m., both dressings, one on RT and Lt heel were 50% saturated. Both dressings were very foul smelling, drainage was a green-tan in color. Did c/o [complain of] pain when old dressings removed, was repositioned which did not help, was medicated with Tylenol 650 mg [milligrams] at 7:00 a.m. Areas cleansed with NS, covered with Tegaderm foam adhesive and wrapped with Kerlix to prevent dressings from falling off. Heels are elevated off the EZ chair, has edema present on top of both feet." A Glenoaks Problem/Fax Sheet dated 10/19/15, sent to MD-A indicated, "1.) Attached are the results of the resident's R heel wound [culture]. Heavy growth noted of proteus species and moderate growth noted to Klebsiella pneumonia. Attached are also culture/sensitivity. Resident will be seeing WOC nurse tomorrow afternoon for bilateral heels which are worsening and Stage II PU noted to bottom over the weekend. 2.) Which antibiotic would you prefer to start resident on? Any other orders?" MD-A responded with orders for Augmentin 875 mg twice daily for 7 days. Although the facility notified the physician of the new stage II pressure ulcer on R53 coccyx, no treatment options were reviewed, and the MD was not made aware of the measurements of the new stage II pressure ulcer to R53's coccyx. Another fax was sent to MD-A on 10/19/15, indicating, "Okay to start resident on Juven [protein drink used to aid with wound healing] 1	2 900		

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2 900	Continued From page 64 packet with 8 oz (ounces) of fluid BID between meals for open areas to Bil (bilateral) heels and Stage II PU to coccyx?" MD-A replied with, "Yes." During interview on 10/19/15, at 9:41 a.m., NA-J stated staff were directed to put heel boots on both R53's feet without socks. NA-J stated this recommendation had been made within the last three weeks because, "[R53] had sores on both heels." During interview on 10/19/15, at 9:44 a.m. NA-K stated R53, "Has trouble with his feet," and should not be wearing shoes or socks. NA-K stated R53 had pressure ulcers on both heels, and she believed it started on the right heel first, and then developed a pressure ulcer to the left heel, "It's been a month that he's had both [pressure ulcers to both heels]." NA-K stated she was directed about 3 weeks ago to only put the boots (heel protectors) on R53, and not to put any socks on the resident. During interview on 10/20/15, at 9:02 a.m. DON stated when staff notified the physician via fax regarding R53's pressure ulcer on 8/14/15, staff should have followed up if they did not receive a response from the physician to ensure there was not a treatment change that needed to be completed. DON stated it was difficult for her to know what took place when R53 developed the first pressure ulcer to the right heel because she was not employed at the facility. DON stated, "The policies and procedures were in place; The procedure wasn't being followed." R14's annual MDS dated 9/8/15, identified R14 had no cognitive impairment, and required extensive assist of two staff for bed mobility, transfers, and toileting.	2 900		

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2 900	Continued From page 65 R14's Care Plan dated 9/18/15, identified the resident was at risk for skin breakdown related to pressure, and R14 was assessed to be turned and repositioned every two hours. Interventions included extensive assist of two staff with repositioning routinely every two hours and as needed, monitor for recurrence of previous pressure ulcer areas, and encourage use of bed and side-lying when in bed. It also identified wound care was to be completed per wound, ostomy, and continence nurse. R14's Physician progress note dated 9/22/15, indicated R14 had a pressure ulcer to her buttock. No staging, measurements, or further assessment of the pressure ulcer was noted. A Referral was made to the wound ostomy clinic. R14's Wound Ostomy Continence (WOC) nurse progress notes dated 10/2/15, indicated R14 was to be frequently repositioned hourly when seated in her chair. On 10/13/15, at 3:42 p.m. R14 was observed lying on her back in bed. R14 stated she did not receive the assistance she needed from staff with repositioning, and she had a "sore" on her buttocks. R14 stated the wound nurse stated she should be turning and repositioning often to relieve pressure, however, she stated she does not get repositioned that often, and, "Is lucky to get help once during the day and once at night." R14 was teary eyed and speaking with a cracking voice. Review of R14's progress notes dated 9/8/15 - 10/16/15, identified the following: - 9/8/15- "Resident c/o [complained of] her	2 900		

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2 900	Continued From page 66	2 900		

buttocks where she has some open sores." There were no measurements or description of the "open sores."
- 9/14/15- Open area to buttock appears slightly larger than a 50 cent piece.
- 9/9/15- Open area is currently slightly larger than a 50 cent piece.
- 9/16/15- Area has increased to 12 centimeters (cm) x 3 cm, almost all open except a few areas to the top and bottom, and surrounding tissue is purple.
- 10/5/15- "Appears to have more open areas near rectum this am [morning]." There was no corresponding assessment of the open area.
- 10/16/15- "Stage II pressure ulcer to buttocks. Erythema across buttocks 11.5 x 8.5 cm. Previous Stage II area on right buttock cheek appears sealed over but is darker Erythema measuring 1.5 x 0.6 cm."

During continuous observation of R14 on 10/14/15, from 7:01 a.m. through 9:45 a.m. the following was observed:

- 7:01 a.m.- R14 was lying in bed on her back.
- 8:35 a.m. NA-C asked R14 if she wanted to get dressed, R14 stated she was not ready to get up yet. NA-C offered R14 coffee, which was declined, and NA-C left the room. R14 was not offered toileting or repositioning.
- 9:29 a.m. LPN-C entered R14's room with her medications. R14's head of the bed was raised, and R14 told LPN-C her heels were sore. LPN-C placed pillows under R14's feet, however, no toileting or repositioning was offered.

Although R14's care plan indicated R14 was at risk for pressure ulcers and was to be repositioned and toileted every 2 hours, the resident was observed for 2 hours and 28 minutes without being offered assistance with

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2 900	Continued From page 67 repositioning or toileting. During interview on 10/14/15, at 9:40 a.m. LPN-C stated R14 was to be repositioned and offered toileting every two hours, and stated the resident should not have gone 2 hours and 40 minutes without staff offering to toilet or reposition the resident. On 10/14/15, at 9:44 a.m. LPN-C and NA-D entered R14's room and assisted R14 onto her right side. R14 was offered toileting at this time, but refused. During a follow up interview on 10/14/15, at 1:09 p.m. R14 stated it is common to put the call light on and wait 15 - 20 minutes for staff assistance, and stated she is frequently incontinent before assistance arrives. R14 also stated staff will walk by when the call light is on, say they will be back, and then turn the call light off without providing assistance. During interview on 10/14/15, at 1:46 p.m. RN-B stated R14 is frequently incontinent of bowel and bladder, and believed staff should be offering R14 assistance with repositioning every hour. On 10/15/15, at 2:35 p.m. RN-B was observed performing a dressing change to the pressure ulcer on R14's buttock. RN-B removed the old dressing and stated the dressing appeared to be completely soiled with feces, and it would be her expectation the nursing assistants would report to nursing if a dressing was soiled so it could be changed. RN-B assessed R14's buttocks and stated the reddened area measured 11.5 cm x 8.5 centimeters (cm), and the smaller, deeper red area measured 1.5 x 0.6 cm. She stated the pressure ulcer was previously a stage II, but was	2 900		

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2 900	Continued From page 68 now a stage I as it was not open. During interview on 10/16/15, at 8:48 a.m. NA-L stated she believed R14 was to be assisted with repositioning every two hours. During interview on 10/16/15, at 10:28 a.m. NA-D stated she believed R14 was to be offered toileting and repositioning every hour, and was always incontinent. During interview on 10/16/15, at 10:58 a.m. RN-A stated she believed R14 was to be offered repositioning and toileting every hour when sitting. RN-A stated R14 would refuse toileting and/ or repositioning at times, however, staff should still be offering and encouraging R14 to toilet and reposition to ensure healing of the pressure ulcer. The facility policy titled, Prevention and Treatment of Skin Breakdown dated 10/10 included, "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." The policy directed if a resident was admitted with, or there was a new development of a pressure ulcer, staff were to notify the physician, dietary, therapy, and the care plan and nursing assistant care sheets with skin concern would be updated. Staff were directed to initiate the Initial Pressure Ulcer Documentation form and the Weekly Ulcer Documentation form, and were to complete daily wound monitoring which included observation of the pressure ulcer or the status of the dressing, area surrounding the ulcer, presence of possible complications such as signs of infection, assess	2 900		

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2 900	Continued From page 69 pain management, and to document any changes or concerns in the nurses notes. The facility policy titled Weekly Ulcer Documentation Form Procedure dated 10/10 directed, "The Initial Ulcer & Weekly Ulcer Documentation form should be started immediately upon identification of pressure ulcer...should be completed at least weekly and as appropriate." The policy directed staff to document stage, length, width, depth, drainage, odor, undermining, tunneling, wound edges, and wound progress, and to notify the physician of any changes. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing, and to promote healing of pressure ulcers. The director of nursing or designee could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing	2 910		

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2 910	Continued From page 70 home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting for 1 of 2 residents (R14) reviewed for urinary incontinence, and who was dependent upon staff for toileting. Findings include: R14's annual Minimum Data Set (MDS) dated 9/8/15, identified R14 to be cognitively intact, require extensive assistance with activities of daily living (ADLs), and have frequent urinary incontinence. R14's Urinary Incontinence Care Area Assessment (CAA) dated 9/8/15, identified R14 to be incontinent of urine on the way to the bathroom. Further, the CAA identified staff were to, "...continue toileting plan of Toilet [sic] upon rising, Q2H [every two hours] during the day, and offer during the NOC [night]. R14's Bladder Assessment dated 9/9/15, identified R14 to have "mixed" incontinence, and listed a treatment program of, "Scheduled	2 910		

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2 910	Continued From page 71 Toileting/Habit Training." Further, the assessment directed staff to help R14 to the toilet every two hours during the day. R14's care plan dated 9/18/15, identified a risk for incontinence with interventions including to help R14 with toileting upon on rising in the morning, every 1 1/2 hours when awake, every two hours at night, and per her request. During continuous observation on 10/14/15, from 7:01 a.m. to 9:44 a.m. R14 was laying in bed in her room. R14 was not offered or provided with any toileting or incontinence cares for 2 hours and 43 minutes. When notified of the lack of toileting or incontinence care for R14 on 10/14/15, at 9:40 a.m. licensed practical nurse (LPN)-C stated R14 should have been assisted with toileting every two hours. During interview on 10/14/15, at 1:09 p.m. R14 stated she will frequently put her call light on and have to wait for 15 to 20 minutes to receive help with toileting, often becoming incontinent before help arrives. When interviewed on 10/16/15, at 10:58 a.m. registered nurse (RN)-A stated R14 was to be offered toileting upon rising, and every one hour while she was awake. Further, RN-A added R14 should have been offered toileting before 2 hours and 44 minutes passed. A facility Urinary Continence and Incontinence - Assessment and Management policy dated 9/2010, identified staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections.	2 910		

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2 910	Continued From page 72 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review and revise policies and procedures related to monitoring and provision of incontinence care, and provide staff education related to the care of residents with urinary incontinence. The director of nursing or designee could develop an audit tool to ensure appropriate and timely incontinence care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 915		

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2 915	Continued From page 73 review, the facility failed to provide and consistently implement ambulation services to improve and/or maintain residents' ambulation abilities for 4 of 5 residents (R57, R35, R28 and R53) in the sample reviewed for restorative nursing services. Findings include: R57's diagnoses, as identified on physician's orders dated 9/16/2015, included intracerebral hemorrhage, hemiplegia and hemiparesis. The quarterly MDS, dated 9/10/2015, indicated R57 required extensive assistance with transferring, bathing and most activities of daily living. The MDS also indicated he had intact cognition. A care area assessment (CAA) for functional status/rehabilitation potential, dated 6/15/2015, indicated R57 required assistance with all ADLs, and was walking with therapy. During observation on 10/14/2015 at 7:45 a.m. nursing assistant (NA)-B assisted R57 with morning cares. R57 used a hemi walker (an assistive walking device) to move from the bed and transfer into his wheel chair, while NA-B used a gait belt to assist R57. In an interview on 10/15/15 at 2:15 p.m., R57 stated he participates in a walking program, but lately he was only getting assistance with walking, "once a day," with two nursing assistants. R57 stated the walks "do not happen on the weekend." A Therapy to Restorative Nursing Communication Form, dated 6/30/2015, indicated R57 was to ambulate with (R57) daily in hallway, using assistance of 1 with gait belt, and 1 to push the	2 915		

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2 915	Continued From page 74	2 915		

wheel chair behind. Walk the length of handrail, 1-3 times per day.

A PT (physical therapy) Therapist Progress and Discharge summary, dated 8/19/2015, indicated R57 had received skilled services including gait training and neuromuscular re-education, which improved R57's abilities "with bed mobility, transfer and ambulation." The discharge plan included "continue walking with restorative nursing and perform LE (lower extremity) strength maintenance program.

A review of R57's Restorative Flowsheets from 7/1/2015 to 10/10/2015 indicated R57 had documented ambulation services:

July 22 of 31 opportunities (no refusals documented)
August 12 of 31 opportunities
September 3 of 30 opportunities
October 2 of 10 opportunities

In an interview on 10/16/2015 at 8:18 a.m., restorative aide (RA)-A stated that R57 had a restorative ambulation program to walk in the hallway, and also that R57 "was pretty persistent about getting his walking done." RA-A said R57's program was missed, but said it was completed more than was documented. RA-A stated R57 had not declined in his ability, even though some walking days were missed. RA-A stated more and more he "was getting pulled" to work on the floor, it seemed "about 50% of the time." RA-A stated lately it was "pretty frustrating" not getting the residents' programs done, even though he was scheduled for rehab more frequently. RA-A said the restorative programs were often missed and not completed on the weekends. RA-A stated if he had questions about a residents restorative program, he would ask the physical or

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2 915	Continued From page 75 occupational therapy department but was not sure who was in charge of the restorative program at the facility. In an interview on 10/16/2015 at 9:41 a.m., registered nurse (RN)-A stated the "nurse managers" were in charge of the restorative programs, that they reviewed "their own resident" and "should be monitoring progress, as well if the programs "are getting done or note." RN-A said she "did not know" if the programs were getting done consistently. RN-A stated there was one primary restorative aide, and her back up is leaving the facility, right now have" not found someone who wants to step in." R35's diagnoses, as identified on the care plan, updated 10/13/2015, included Parkinson's disease, weakness, and history of falling. The quarterly Minimum Data Set (MDS), dated 6/25/2015, indicated R35 required extensive assistance with transferring, and activities of daily living. The MDS also indicated R35 had intact cognition. The CAA for ADLs Functional Status/Rehabilitation Potential, dated 3/25/2015, indicated she had an acute decline in ADLs and mobility and increased weakness related to a recent GI blood. The CAA also indicated R35 had Parkinson's, which impacted her independence and ADLs. A PT -Therapist Progress & Discharge summary, dated 5/17/2015, indicated R35 received physical therapy from 3/19/2015 to 5/17/2015. The report indicated R57 "...has shown gains in strength, activity tolerance and neuromuscular function which allowed for increased distances walking and improved transfers and ambulation." The discharge plan included "Recommendation	2 915		

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discussed with patient and/or caregivers include Restorative Nursing program."

A review of Glen Oaks Care Center - Oak nursing assistant care sheet, printed 10/16/2015, directed "walk [R57] to and from DR (dining room) TID (three times a day) as tolerated."

In an interview on 10/16/2015 at 11:32 a.m., RA-B stated R35 "had no formal restorative program," but that she was to be walked from her room to the dining room, as much as she could. RA-B stated R35 was not always a willing participant, and needed encouragement, but that is was important for her to keep walking. RA-B was not sure where R35's walking was documented.

In an interview on 10/16/2015 at 9:33 a.m., R35 stated during cares she "walk to the bathroom, I did that yesterday." R35 also said she "sometimes refuses to walk," but the staff has not asked me to walk "for a long time." R35 also said she walked more a couple months ago, "in summer they would take me," but not of late. R35 also said her feet hurt when she walked, "and my balance is off."

During observation on 10/19/2015 at 12:05 p.m., R35 was seated in her wheel chair, prior to the start of lunch, and NA-G pushed R35 from her room into the dining area. NA-G did not offer to ambulate R35.

In an interview, on 10/19/2015 at 12:08 p.m., NA-G said she "did not know" R35 was on a walking program.

In an interview on 10/19/2015 at 3:08 p.m., NA-N stated R57 "has not walked down the the dining room this past week." NA-N stated during his

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afternoon shift, he has asked R57 to ambulate, and the past couple of times "she has refused," and instead would rather be pushed in her wheel chair. NA-N stated he was not aware if R57 was on a walking program.

In an interview on 10/19/2015 at 3:01 p.m., registered nurse (RN)-B stated she did not know whether R35's walking program "was documented anywhere." RN-B said since most recent care conference, R35 expressed her legs were hurting more, and was refusing more to walk. RN-B also stated her walking program "is on the CNA care sheet", and that the nursing assistants "are supposed to document." RN-B added that "right now" the walking and restorative programs were not getting monitored, and "probably were not recorded."

In an interview on 10/19/2015 at 3:12 p.m., NA-O stated R35 "was able to walk, if people would take her." NA-O stated the nursing assistants used to record ambulation in a book, but now recorded distances "on the aide sheets." NA-O said the sheets were to be turned in every day, "but I have not seen them get turned in lately." NA-O said she "did not know" if all the aides were aware of this. NA-O said the facility had this concern before, where residents did not get walked, or their restorative programs, then staff would get reminders, "and it improved for a while, then kinda goes by the wayside." NA-O also said [walking] is the care sheets, "and it would be expected that we do it." NA-O also said she thought the real issue "was time, and not enough help."

In an interview on 10/20/2015 at 9:18 a.m., the physical therapist (PT) stated the facility "should have a stronger follow up program after residents

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are discharged from therapy. The PT said in the past, "we had a weekly meeting with the RN in charge of the resident and the rehab aid" and "every resident would be discussed" at least monthly, and it "did not matter" whether a resident was getting therapy or was on a range of motion or walking program." The PT said it was a way for us to "catch things" before a resident lost functionality. The PT said restorative programs "were not" consistently completed and it was difficult to get and retain qualified staff, but "we still have to take care of the residents."

R28's 5-day MDS dated 8/26/15, indicated R28 had severe cognitive impairment, and required extensive assistance of two staff for transferring and toileting. The MDS further indicated R28 had no episodes of rejecting cares, did not walk in the room or corridor during the assessment period, and used a wheelchair for mobility.

R28's care plan dated 10/9/15, directed staff to ambulate R28 to and from meals, as tolerated with extensive assistance.

A review of R28's Physical Therapy Plan of Care dated 8/21/15, identified a long term goal which included, "[R28] will ambulate daily with nursing staff 100 feet safely with front wheeled walker and contact guard assist on even surfaces."

During observation of personal cares on 10/14/15, at 9:20 a.m. NA-C assisted R28 using a mechanical lift to transfer into his wheelchair. R28 then propelled himself in his wheelchair with his feet into the hallway. An unidentified staff walking by R28's room, offered to push him to the dining room for breakfast, which he accepted.

During interview on 10/16/15, at 11:28 a.m.

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restorative aide (RA)-A stated R28 was not on the restorative program, but staff were directed to walk him as directed on the care plan. RA-A stated R28 walked well with a walker for short distances.

During interview on 10/16/15, at 11:38 a.m. health information coordinator (HIC)-A stated R28 had been admitted to the facility three times in the past, and would transfer himself into the recliner. HIC-A stated R28 does not ambulate as much now because he propels himself in the wheelchair with his feet.

During interview on 10/16/15, at 12:01 p.m. NA-G stated R28 does not walk, and she was not aware nursing was supposed to be walking R28.

During interview on 10/16/15, at 12:14 p.m. HIC-A stated the former RN case manager placed R28's restorative nursing on hold after his most recent hospitalization on 8/17/15, because he was working with therapy at the time, and was waiting to see what therapy recommended. HIC-A stated she was not aware of the new Physical Therapy Plan of Care dated 8/21/15, which directed staff to ambulate the resident daily with nursing staff 100 feet.

During interview on 10/16/15, at 1:14 p.m. PT-A stated physical therapy made a recommendation to nursing on 8/21/15, after R28's last hospital return, to walk with staff daily 100 feet. PT-A was unable to find any communication of this direction to nursing, and stated it must had gotten missed.

On 10/16/15, at approximate 1:20 p.m. PT-A assisted R28 to walk approximately 90 feet. PT-A stated R28 did not have a decline in ambulation, and would ensure nursing was aware of the

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2 915	Continued From page 80 recommended to walk R28 daily to maintain current ambulation ability. R53's quarterly MDS dated 9/16/15, identified R53 had moderate cognitive impairment, required extensive assistance of one for transferring, and had walked once or twice with extensive assistance in his room and corridor. In addition, the MDS identified R53 had no displays of behavior or rejection of cares. During an observation on 10/13/15, at 3:47 p.m., R53 was lying in bed, on the left side, with his blankets over head. When approached, R53 rolled slightly onto his back, with both knees bent. R53's Care Area Assessment, dated 6/11/15, identified, "Res [resident] at risk r/t [related to] diagnoses: hemiparesis (LEFT), TIA, DM, PVD, and HX [history] of hamstring contractures. Requires ext [extensive] assist with bed mobility, transfers, ambulation, locomotion...Impaired functional ROM to (B) LE [bilateral lower extremities]. He does have (B) hamstring contractures. Currently working with OT (occupational therapy) to regain some ability to ambulate and stand better." A review of a progress note, dated 6/17/15, identified R53 had been discharged from therapy on 6/16/15, and, "Therapy recommends restorative. Recommendations include ambulate to meals as tolerated to stretch hamstrings with feet and lower legs on bolster for several minutes to facilitate mobility. Resident is on the list to ambulate to meals with staff. Will place on ambulation program with restorative as well and sit to stand at bar to stretch hamstrings d/t [due	2 915		

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to] contractures."

R53's care plan, dated 9/16/15, included, "Staff offer to walk to and from BR [bathroom] as he is able and in halls per his wishes with walker and w/c [wheelchair] to follow."

A review of the Glenoaks Care Center-Maple 1 nursing assistant care sheet, undated, directed staff to, "Amb [ambulate] to/from meals DAT [distance as tolerated] w/ [with] walker et [and] w/c."

Review of R53's Therapy to Restorative Nursing Communication Form, dated 6/16/15, indicated R53's goals to work towards, were transfers, standing, and mobility, and included, "Ambulate to meals as tolerated. Can stretch hamstrings w/ feet and lower legs on bolster for several minutes to facilitate mobility...Encourage Pt [patient] to participate as much as possible."

Review of the Restorative Flowsheets from 6/17/15 -10/19/15, indicated the ambulation program had been completed as follows:

June 2015 7 of 13 opportunities
July 2015 23 of 31 opportunities with 2 refusals
August 2015 10 of 31 opportunities with 3 refusals
September 2015 5 of 30 opportunities with 1 refusal
October 2015 0 of 19 opportunities with 2 refusals

During an interview on 10/16/15, at 2:11 p.m., R53's family member (FM)-A stated, "I'm concerned because there was a Hoyer [mechanical lift] sling in [R53's] recliner today.

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He's supposed to be walked. They are so understaffed." FM-A stated R53 had potential to become more contractured if staff weren't walking and stretching his legs.

During an interview on 10/16/15, at 2:35 p.m., restorative aide (RA)-B stated R53 had a restorative program since 6/17/15 for ambulation. RA-B stated, "Therapy wanted me to walk him. He's supposed to walk every day. Sometimes he doesn't want to walk but will always do his pull ups." RA-B also stated, "I try to walk him every day but I get pulled to work on the floor. With the shortage of staffing, it doesn't get done."

During an interview on 10/16/15, at 3:05 p.m., certified occupational therapy assistant (COTA) stated, "When we discharge a resident from therapy and recommend restorative nursing, that becomes a nursing program." She would expect the nursing staff to monitor residents receiving restorative program and discuss concerns at the Interdisciplinary Team (IDT) meetings, which the physical therapist and COTA attended.

During an interview on 10/19/15, at 11:59 a.m., registered nurse (RN)-A reviewed the Point of Care documentation in R53's electronic medical record, and stated, "The last time [R53] was walked in his room and in the hallway [by nursing assistants] was on 9/14/15."

Facility policy titled Range of Motion Exercises revision date 10/10, identified the following should be recorded in the resident's medical record:
- the date and time that the exercises were performed
- the name and title of the individual(s) who performed the procedure
- the type of range of motion exercise given

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BENEDICTINE LIVING COMMUNITY OF NEW LONDON	100 GLEN OAKS DRIVE NEW LONDON, MN 56273

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2 915	Continued From page 83 - whether the exercise was active or passive - how long the exercise was conducted Reporting - notify the supervisor if the resident refuses the exercises - any problems or complaints made by the resident related to the procedure - any changes in the resident's ability to participate in the procedure - if the resident refused the treatment, the reason(s) why and the intervention taken - report other information in accordance with facility policy and professional standards of practice SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to activities of daily living (ADLs), and provide staff education related to appropriate and timely provision of ADLs for residents. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases;	21390		

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21390	Continued From page 84 C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an infection control program to include consistent monitoring, trending and analysis of infections to reduce the transmission to other residents in the facility. This had potential to affect all 47 residents residing in the facility. In addition, the facility failed to ensure handwashing was completed to reduce the potential spread of infection for 4 of 6 residents (R24, R31, R14, R57) whose cares were observed during the survey. Findings include: LACK OF COMPREHENSIVE INFECTION CONTROL PROGRAM:	21390		

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21390	Continued From page 85 An untitled infection log document dated June 2015, identified a flowsheet for staff to record resident infections. The flowsheet identified seven residents experienced an infection in the facility since 6/1/15, with the last recorded infection being on 9/17/15. The flowsheet provided spaces to record the following information to track and trend infections: > Date > Resident Name > Organism/Culture Results > Room Number > If Present Upon Admission > Type of Infection (i.e. urinary tract infection [UTI], gastrointestinal illness [GI], etc.) and, > Antibiotic (with start and end dates). The flowsheet consistently identified the residents name, date of infection, and type of infection, however it lacked consistent organism identification, and antibiotic start and stop dates as directed be filled out by the flowsheet. A separate facility Care Center Infection log dated September 2015, was provided and identified a different flowsheet in which staff recorded infections. The form included spaces to identify the following information: > Resident name > Room > If present upon admission > Organism > Type of infection (i.e. urinary tract infection (UTI), gastrointestinal infection (GI), etc) The September 2015 data listed ten residents as having an infection for the month. R26, R28, and R29 were identified has having an "emesis" written underneath of the "Organism" heading, and were located in adjacent rooms on the Maple Lane unit. R26, R28 and R29 were all identified	21390		

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21390	Continued From page 86 has having a "GI" infection on the report. Further, the report identified three residents had a UTI, two residents had a lower respiratory infection, and one resident had a skin infection. However, the log lacked consistent identification of the organisms causing the infection, symptoms of the infection, nor the date they started or resolved, documentation of the room for each resident, and the start or stopping date of antibiotics which were used to treat each resident. An undated facility September 2015 Infections report identified the documented analysis of the collected information as presented by the facility. The report identified the Maple Lane unit experienced, "Three different residents with episodes of vomiting without complications", however added there was, "No patterns noted among residents and staff" despite the residents being on the same unit, in adjacent rooms, and having the same symptoms on 9/7/15, 9/13/15, and 9/20/15. During interview on 10/20/15, at 1:05 p.m. registered nurse (RN)-A and the director of nursing (DON) stated RN-A was responsible for the collection and analysis of the infection data. The data is reviewed by RN-A, an analysis is typed up and attached to the data (i.e. September 2015 infections report) and it is discussed at the monthly Quality Assurance (QA) meetings. RN-A stated no tracking or trending was completed of resident symptoms, date they began and ceased. The organism(s) were tracked on the flowsheet's provided, and no further documentation was identified besides what was provided to the surveyors as their infection control program. A facility policy on the infection control program was requested, but none was provided.	21390		

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21390	Continued From page 87 ANTIBIOTIC STEWARDSHIP: An undated facility June 2015 Infections Report identified R2, whom resided on the Pine Lane unit, completed a "third round of ABT [antibiotic] after having positive recheck UA/UC [urinary analysis / urinary culture]." The report identified the, "Final recheck was negative with no significant growth." However, the report did not identify any signs or symptoms R29 was experiencing to warrant a repeat urine screening or antibiotic treatment. A Facility Event Summary Report dated 6/1/15 to 6/30/15, identified R29 had a "UTI identify [sic] that grew out e-coli [a bacteria] ... Started on Ceftin [an antibiotic] 250 mg BId [sic, twice a day] x 10 day [times 10 days] ... [R29] does not have symptoms of UTI..." During interview on 10/20/15, at 1:09 p.m. RN-A stated it was up to the physician to determine if a repeat UA/UC should be obtained, "It's the physician decision", and only one of the physicians who see residents at the facility did not routinely order a follow-up urine screening. Further, RN-A stated most of the physicians do request a follow-up urine screening and some are treated with antibiotics despite the lack of symptoms. LACK OF HAND HYGIENE DURING CARES: During observation of morning cares on 10/14/15, at 7:59 a.m. nursing assistant (NA)-A completed perineal cares using gloved hands. NA-A assisted R24 to turn onto the left side in bed, and cleaned incontinent stool from R24's buttocks. With his soiled gloves NA-A proceeded to pull up	21390		

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21390	Continued From page 88 R24's pants, adjust his shirt, and apply a foot brace to his left foot. He continued with his soiled gloves and removed the gait belt and placed it on the bed; unlocked R24's wheelchair brakes placing it next to the bed touching both handles of the chair. NA-A cleaned up the used supplies in the room, then removed his soiled gloves disposing of them in the trash. NA-A left R24's room without washing his hands or performing any further hand hygiene, and assisted another staff member with a transfer of a different resident. During an interview on 10/14/15, at 8:49 a.m. NA-A stated he should have removed the soiled gloves after performing perineal care, and should have washed his hands prior to leaving R24's room to help with another resident, "I know that. I was just nervous." During observation of morning cares on 10/15/15, at 6:28 a.m. R31 was being assisted by nursing assistant (NA)-H with dressing. NA-H removed R31's incontinence pad with gloved hands, completed perineal cares and applied a new incontinence pad. NA-H removed her soiled gloves and assisted R31 to turn onto his side, placing a mechanical lift sling underneath of him. NA-H left the room and returned with a mechanical lift to transfer R31 from bed to his chair. NA-H did not wash her hands after removing her gloves which were used to complete perineal cares for R31. NA-H assisted R31 to the commons area in his wheelchair, returned to his room and cleaned up the used supplies from his morning cares. NA-H washed her hands after placing the soiled linens in the soiled utility closet. When interviewed on 10/15/15, at 1:37 p.m.	21390		

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21390	Continued From page 89 NA-H stated she should have washed her hands after removing her gloves when caring for R31. During observation of wound care on 10/15/15, at 2:35 p.m. registered nurse (RN)-B applied a pair of disposable gloves and assisted R14 off a bedpan. RN-B completed perineal cares using her gloved hands, then removed the old dressing from R14's buttock. RN-B did not perform handwashing, or change her gloves after performing perineal care prior to removing the dressing from R14's buttock. RN-B stated the old dressing appeared to be completely soiled with feces, and the nursing assistants should have reported it. RN-B removed her soiled gloves, and applied new ones without washing her hands. RN-B proceeded to measure the wound on R14's buttock, and prepare a new dressing to be applied to the wound using her gloved hands. RN-B removed the gloves, and RN-B left the room to retrieve a different type of dressing which was applied to R14's buttock. RN-B did not wash her hands after removing her soiled gloves. During interview on 10/15/15, at 3:04 p.m. RN-B stated she did not complete hand hygiene, including washing her hands, after removing her gloves, but should have. A facility Dressing, Dry/Clean policy dated 2/2014, identified staff should use clean gloves to remove any soiled dressings, and wash their hands after removing any gloves. During observation of morning cares on 10/14/15 at 8:10 a.m., nursing assistant (NA)-C provided perineal cares for R57 using gloved hands. Afterwards, NA-C took the used wash basin and	21390		

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21390	Continued From page 90	21390		

cloth into the bathroom and removed her gloves. Without washing her hands, NA-C donned a new pair of gloves, and placed R57's stockings on his feet, followed by R57's shoes. NA-C entered the bathroom, rinsed R57's dentures, and, with the same gloved hands, held R57's dentures so R57 could insert them. While continuing to wear the same gloves, NA-C gave R57 his glasses, then bagged up soiled clothing, as well as the garbage, and placed a new liner in the trash can. After depositing the bagged items in the soiled utility area, NA-C returned to R57's room, with hands still unwashed.

In an interview on 10/14/15, at 8:28 a.m., NA-C stated she should wash her hands "before and after cares." NA-C stated she usually just "changes gloves" and that she uses "alcohol scrubs" to cleanse her hands.

When interviewed on 10/16/2015 at 11:06 a.m., licensed practical nurse (LPN)-A said all staff had "training annually for infection control." LPN-A stated staff actually "have to demonstrate handwashing." LPN-A said handwashing was done "before and after" resident cares, after toileting, with any bodily fluid contact, "even if you wear gloves."

When interviewed on 10/15/15, at 1:39 p.m. RN-C stated hand hygiene, including hand washing, should be performed after perineal care is provided, and after gloves are removed.

When interviewed on 10/16/15, at 10:49 a.m. RN-A stated hand hygiene should be performed after perineal care, and anytime after gloves are removed.

A facility Perineal Care policy dated 10/2010,

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21390	Continued From page 91 identified staff should remove their gloves when completed, then wash and dry their hands. A facility Handwashing / Hand Hygiene policy dated 8/2014, identified staff should use an alcohol-based hand sanitizing rub or soap and water after direct contact with residents, before handling clean or soiled dressings, and after removing gloves. Further, the policy identified gloves were not to be used to replace hand washing. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or their designee should review the facility's policy and procedures for monitoring, tracking, trending and analyzing infections treated within the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.	21830		

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21830	Continued From page 92 (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not	21830		

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21830	Continued From page 93 liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to following morning routine preferences for 1 of 1 residents (R24) reviewed for choices.	21830		

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21830	Continued From page 94 Findings include: R24's annual MDS, dated 7/22/15, indicated R24 had intact cognition, and required extensive assistance from staff to complete his activities of daily living. During an interview on 10/12/15, at 6:15 p.m. R24 stated he wanted to be up in the morning by 6:30 a.m., but for approximately the last two months, that had not been happening. R24 stated, "Today, it was 8:30 before they came in to get me up," adding, "Sometimes I hear them complain that they are short of help." A review of the Glenoaks Care Center-Maple 2 nursing assistant care sheet, undated, included, "Likes to get up at 5:30 a.m." During observation on 10/14/15, at 7:54 a.m. R24 was still in bed. NA-A entered R24's room and stated he was going to get R24 up. R24 stated, "I should be up by now. I like to be up by at least 6:00 a.m." NA-A did not respond. During an interview on 10/14/15, at 8:49 a.m., NA-A stated he was "new here", but staff typically get the residents who require assistance with eating up first and get everyone else up later. NA-A stated staff try to get to R24 "as soon as we can." Further, NA-A was unaware of R24's preference to be up early. When interviewed on 10/20/15, at 10:54 a.m. LPN-C stated R24 liked to be up between 5:30 a.m. and 7:00 a.m., but helping him during those times "depends on what else is going on in the building." Further, LPN-C stated the night shift did not typically help residents with morning cares.	21830		

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21830	Continued From page 95 During interview on 10/20/15, at 10:56 a.m. NA-I stated, "[R24] likes to get up at 5:30, but night shift won't do it. They make him wait." Further, NA-I stated R24 complains to her and she has told the nurses, but nothing has changed. When interviewed on 10/16/15, at 12:02 p.m. the director of nursing (DON) stated there is often not enough staff to get residents up in the morning, but the goals was to "to honor all resident choices." An undated facility Quality of Life-Self Determination and Participation policy indicated the facility, "Respects and promotes the right of each resident to exercise his or her own autonomy regarding what the resident considers to be important facets of his or her life." Further, the policy identified each resident "shall be allowed to choose activities, schedules and health care that are consistent with her or her own interest, assessments and plans of care..." SUGGESTED METHOD OF CORRECTION: The administrator or designee could re-educate staff on soliciting and assessment of resident preferences, and conduct audits to ensure resident choices are obtained, care planned, and provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		