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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C98F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245319**

2. STATE VENDOR OR MEDICAID NO. (L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LA CRESCENT**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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) **04/01/2006**

6. DATE OF SURVEY **11/15/2016** (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 **45** (L18)

13.Total Certified Beds **45** (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, 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):

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

17. SURVEYOR SIGNATURE — Date :
Connie Brady, HFE NE II — 12/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 12/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (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) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245319

December 13, 2016

Ms. Abby Rand, Administrator
Golden LivingCenter - La Crescent
101 South Hill Street
La Crescent, MN 55947

Dear Ms. Rand:

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 November 11, 2016 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

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

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 12, 2016

Ms. Abby Rand, Administrator
Golden LivingCenter - La Crescent
101 South Hill Street
La Crescent, MN 55947

RE: Project Number S5319025

Dear Ms. Rand:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 26, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 25, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 30, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on August 26, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 18, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 15, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 15, 2016, as of November 11, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 11, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 25, 2016. 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

November 26, 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 November 26, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 26, 2016, is to be rescinded.

In our letter of October 25, 2016, 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 November 26, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 11, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect.
Therefore, the NATCEP prohibition is rescinded.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245319		11/15/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 11/11/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 12/12/2016	SIGNATURE OF SURVEYOR 28651	DATE 11/15/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 13, 2016

Ms. Abby Rand, Administrator
Golden LivingCenter - La Crescent
101 South Hill Street
La Crescent, MN 55947

RE: Project Number S5319025

Dear Ms. Rand:

On October 25, 2016, this Department recommended the following action to the CMS RO for imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 26, 2016. (42 CFR 488.417 (b))

Also, on October 25, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 30, 2016 (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on August 26, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 18, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 15, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 11, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on November 15, 2016, as of November 11, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 11, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 25, 2016. 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 November 26, 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 November 26, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 26, 2016, is to be rescinded.

In our letter of October 25, 2016, 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 November 26, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 11, 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 visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00936		11/15/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20860 Reg. # MN Rule 4658.0520 Subp. 2 F. LSC	Correction Completed 11/11/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** GPN/kfd	**DATE** 12/13/2016	**SIGNATURE OF SURVEYOR** 28651	**DATE** 11/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/26/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C98F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245319**

2. STATE VENDOR OR MEDICAID NO. (L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LA CRESCENT**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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) **04/01/2006**

6. DATE OF SURVEY **10/18/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B, 5** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):

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

17. SURVEYOR SIGNATURE Date : Wendy Buckholz, HFE NE II 11/3/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 12/7/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (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) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered

October 25, 2016

Ms. Abby Rand, Administrator
Golden LivingCenter - La Crescent
101 South Hill Street
La Crescent, MN 55947

RE: Project Number S5319025

Dear Ms. Rand:

On September 12, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 26, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 18, 2016, the Minnesota Department of Health 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 August 26, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 23, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 26, 2016. The deficiencies not corrected are as follows:

F0312 483.25(a)(3) -- Adl Care Provided For Dependent Residents S/S: D

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 30, 2016. (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 November 26, 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 November 26, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 26, 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, Golden Livingcenter - La Crescent is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 26, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

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

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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved

and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 February 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	R 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 October 18, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there is one tag that was not found corrected at the time of onsite PCR which is 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 312} SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail and hand hygiene for 2 of 3 residents (R9 and R12) who were assessed to need assistance by staff to meet their activities of daily living (ADL's) needs. Findings include:	{F 312}	1. Nail care and hand hygiene have been provided for R9 and R12. 2. Residents who are unable to carry out activities of daily living have the potential to be affected. 3. Education has been provided to nursing staff on providing dependent residents	11/11/16

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

Electronically Signed | 11/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	R 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 312}	Continued From page 1 R12 had been observed on 10/17/16, at 2:47 p.m. to be located in the dining room. During observation R12 was noted to have very long fingernails which had brown debris underneath nails as well on several cuticle areas. R9 had a palm protector in place on left hand and when fingers were moved there was a foul odor coming from the skin. On 10/18/16, at 10:00 a.m. R12 was observed lying in bed. Nails remained long with debris under the nails. No palm protector was in place on R12's left hand and when left hand was opened it was damp looking and a very strong sour/foul odor was noted. R12 stated staff had not put "that thing [splint] on my hand. I am supposed to have that on and my hand washed." Neither had been provided per R12. R12's quarterly Minimum Data Set (MDS) assessment dated 8/10/16, included a Brief Interview for Mental Status (BIMS) assessment score of 11 indicating moderate cognitive impairment. The MDS also identified that R12 required extensive assistance with ADL needs especially personal hygiene. Review of R12's current resident care sheet identified R12 received a weekly bed bath on Friday mornings and had a splint to the left hand that was to be removed daily for hygiene. Review of the bath schedule for 10/14/16, identified R12 had received a bath. The bath schedule identified staff were to "PLEASE REMEMBER TO DO NAIL CARE!!" The care plan revised 8/24/16, identified R12 required assistance of one staff with personal hygiene and nail care as needed. R12 also had a physician's order to remove her	{F 312}	assistance they need to meet their activities of daily living needs. 4. DNS or designee will completed random audits of dependent resident's nail care weekly X 4 weeks, then monthly X 2 months. Results will be communicated to facility QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	R 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 312}	Continued From page 2 palm guard in the a.m. with cares and complete hand hygiene. When interviewed on 10/18/16, at 10:30 a.m. the assistant director of nursing (ADON) confirmed the odor coming from R12's left hand and stated staff should have washed her hand and applied her palm protector. She also confirmed R12's fingernails were not cleaned and should have had nail care provided per the plan of care. R9 had been observed on 10/17/16, at 3:19 p.m. to be seated in a recliner. R9 was noted to have several long chin hair on the left side of chin and fingernails had black and brown debris underneath nails. On 10/18/16, at 10:39 a.m. R9 was again observed sitting in a recliner. Chin hairs had been removed however, the fingernails continued to have black and brown debris underneath nails. R9's significant change MDS dated 9/5/16, identified R9 with a Brief Interview for Mental Status (BIMS) score of 4 indicating R9 had severe cognitive impairment. The MDS also identified that R9 was totally dependent on staff for ADL especially personal hygiene. Review of R9's current resident care sheet identified R9 received a weekly bath on Sunday mornings. Review of the bath schedule for 10/16/16, identified R9 had received a bath. The bath schedule identified staff were to "PLEASE REMEMBER TO DO NAIL CARE!!" The care plan revised 9/19/16, identified R9 required assist of one or two with personal hygiene and nail care as needed.	{F 312}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	R 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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 312}	Continued From page 3 When interviewed on 10/18/16, at 10:30 a.m. the assistant director of nursing (ADON) confirmed R9's nails were soiled. She verified R9 had a bath on 10/16/16, and nail care should have been performed but had not. Review of the facility policy for bathing, last reviewed 12/7/15, included: To Give special care to umbilicus, folds of skin, hands and feet. Also included care of fingernails and toenails is part of the bath. Be certain nails are clean.	{F 312}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245319 Y1	A. Building B. Wing Y2	10/18/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	09/23/2016	LSC	09/23/2016	LSC	09/23/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0323	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(h)	Completed
LSC	09/23/2016	LSC	09/23/2016	LSC	09/23/2016
ID Prefix F0431	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/23/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	10/25/2016	31767	10/18/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/26/2016

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

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on November 15, 2016.

November 15, 2016

Ms. Abby Rand, Administrator
Golden LivingCenter - La Crescent
101 South Hill Street
La Crescent, MN 55947

Re: Project # S5319025

Dear Ms. Rand:

On October 18, 2016, 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 August 26, 2016 with orders received by you electronically on September 12, 2016.

State licensing orders issued pursuant to the last survey completed on August 26, 2016 and found corrected at the time of this October 18, 2016 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on August 26, 2016, found not corrected at the time of this October 18, 2016 revisit and subject to penalty assessment are as follows:

20860 - MN Rule 4658.0520 Subp. 2.F - Adequate and Proper Nursing Care; Hands-Feet - $350.00

The details of the violations noted at the time of this revisit completed on October 18, 2016 (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, electronically acknowledge and date this form and submit 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 $350.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until 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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	R 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(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
2 000	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:	2 000		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	R 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	**101 SOUTH HILL STREET LA CRESCENT, MN 55947**

(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
2 860	Continued From page 1 adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by:	2 860		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00936 Y1	A. Building B. Wing Y2	10/18/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20265	Correction	ID Prefix 20565	Correction	ID Prefix 20830	Correction
Reg. # MN Rule 4658.0085	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix 21426	Correction	ID Prefix 21610	Correction	ID Prefix 21915	Correction
Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1340 Subp. 1	Completed	Reg. # MN St. Statute 144.651 Subd. 27	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix 21980	Correction	ID Prefix 22000	Correction	ID Prefix	Correction
Reg. # MN St. Statute 626.557 Subd. 3	Completed	Reg. # MN St. Statute 626.557 Subd. 14 (a)-(c)	Completed	Reg. #	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	10/25/2016	31767	10/18/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/26/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C98F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245319**

2. STATE VENDOR OR MEDICAID NO. (L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - LA CRESCENT**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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) **04/01/2006**

6. DATE OF SURVEY **08/26/2016** (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 **45** (L18)

13.Total Certified Beds **45** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):

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

17. SURVEYOR SIGNATURE — Date :
Pamela Manzke, HFE NE II — 09/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 10/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (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. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 12, 2016

Ms. Abby Rand, Administrator
Golden LivingCenter - La Crescent
101 South Hill Street
La Crescent, Minnesota 55947

RE: Project Number S5319025

Dear Ms. Rand:

On August 26, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 26, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number .

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

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 October 5, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 5, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 26, 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 February 26, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245319	A. BUILDING _____ B. WING _____	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=G	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 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	F 157		9/23/16

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

Electronically Signed | 09/22/2016

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F 157	Continued From page 1 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 observation, interview and document review, the facility failed to notify the physician of pain/injury following a fall for 1 of 3 residents (R9) who had a fall that resulted in harm evidenced by pain related to a fracture of the femur for R9. Further, the facility failed to notify the physician of significant bruising for 1 of 1 resident (R38) with significant bruising of unknown origin when initially identified. Findings include: R9's admission record identified diagnoses including dementia and osteoporosis without current pathological fracture. R9 was observed on 8/22/16, at 5:24 p.m. sitting in her room in her wheelchair. She was restless and moaning. An interview was attempted about her restlessness and moaning but R9 was unable to respond appropriately to questions. R9's significant change Minimum Data Set (MDS) assessment dated 5/18/16, identified R9 with a Brief Interview for Mental Status (BIMS) score of 00 indicating R9 had severe cognitive	F 157	1. Physician has been notified of fall with fracture involving resident R9 and of bruise of unknown origin for R38. 2. All residents with change in condition had potential to be affected. 3. Licensed nursing staff have been educated on timely notification of physician of resident with change in condition. 4. DNS or designee will complete random audits of residents with change in condition weekly for four weeks and then monthly for 2 months. Results will be communicated to facility QAPI committee.	

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F 157	Continued From page 2	F 157		

impairment. The Care Area Assessment (CAA) associated with the MDS identified R9 was at risk for falls and fall related injuries and required extensive assistance of 2 staff with transfers.

During review of the nurses notes the following entries were noted:

On 8/21/16, at 9:54 p.m. the note identified a change of condition situation had occurred. It was documented in the note that R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The note further identified minimal pain to the right side and that R9 had reddish colored bruises on her right upper back under her right arm. The note also identified R9 stated she had pain "all over."

On 8/22/16, at 8:53 a.m. a note identified that R9 had complained of right thigh pain at 6:00 a.m., and was unable to stand and required staff to use a full lift to transfer R9.

On 8/22/16, at 4:31 p.m. a note identified R9 was complaining of pain to her right thigh while transferring in the EZ stand (mechanical lift device).

On 8/22/16, at 10:28 p.m. a note identified R9 was having marked weakness when attempting to utilize the EZ stand and was not able to transfer safely. The note further indicated a full lift was used to transfer R9 back to bed at bedtime. R9 was noted to have a 6 centimeter (cm) red scrape below her left rib cage, on the outer aspect of her left chest. An addendum to the note on 11:27 p.m. clarified the scrape was on the right not the left. The note also identified R9

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had a large light purple hematoma (bruise) that was raised and staff were able to cup their palm around the entire hematoma, The hematoma was identified as being firm to touch and measured 6 cm by 12 cm. R9's upper trochanter area was warm to touch. R9 was noticed to wince in pain with use of the lift as well as when rolled gently in bed.

On 8/23/16, at 8:35 a.m. a note identified R9 was transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement.

R9 was transferred to the hospital at 10:50 a.m. on 8/23/16. A note from the emergency room (ER) dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.)identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.

During interview on 8/23/16, at 11:01 a.m. nursing assistant (NA)-I stated she did not get R9 up that morning. NA-I stated night shift got R9 up. NA-H stated when she transferred R9 to the wheel chair that day she used a full body lift rather than the EZ stand as R9 was sore on the right side.

During interview on 8/23/16, at 2:25 p.m. NA-J

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stated R9 utilized an EZ stand lift. NA-J stated the instructions to use the EZ stand lift were indicated on the NA care sheet that the aides carry with them.

During interview on 8/23/16, at 2:32 p.m., NA-D stated she was working the evening shift on 8/22/16. NA-D stated when she went to get R9 up out of her recliner with the EZ lift, R9 was leaning way to the left putting all of her weight on the left side, which was not usual for R9. NA-D stated R9 could not stand and was wincing with pain. NA-D stated at that time she notified the nurse immediately. NA-D stated that when she went in to put R9 to bed later that evening she again attempted to use the EZ lift and R9 would not put any weight on her right leg and was very pale and weak. NA-D stated staff then used a full body lift to get R9 into bed. NA-D stated she again told the nurse of R9's condition and the nurse then went to check on R9 and took vital signs (VS).

During interview on 8/24/16, at 11:21 a.m. the assistant director of nursing (ADON) stated that when R9 was unable to transfer her typical way, going from an EZ lift to a full body lift, the situation should have been looked into and warranted further investigation. The ADON stated, "This would be considered a change of condition for R9."

During interview on 8/24/16, at 3:05 p.m. NA-H stated she was transferring R9 from the commode to the bed on 8/21/16 and utilized a transfer belt. During the transfer R9 got her heel caught on the commode and when NA-H went to turn to get the resident onto the bed, R9 fell into her and NA-H slid R9 to the floor. NA-H stated

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R9 grabbed her right leg and complained of pain.

During interview on 8/24/16, at 3:32 p.m. registered nurse (RN)-C stated she was working the day shift on 8/22/16. RN-C stated that at approximately 10:00 a.m. an aide told her R9 was having trouble keeping her feet on the EZ lift. RN-C stated that NA-A had reported to her that R9 was moaning and groaning a lot and complaining of her leg hurting. During interview on 8/24/16, at 2:55 p.m. RN-A stated she had worked the evening of 8/22/16. RN-A stated she was told in report that R9 was transferring poorly during the day. RN-A stated the aides didn't feel safe transferring R9 with the EZ stand lift. RN-A stated staff asked her to go look at R9 which she did and she took R9's v.s. which were fine. RN-A further stated R9 was grimacing and appeared to be in a lot of pain when she was assisted into bed. RN-A also stated, at around 10:00 p.m. she notice R9's right leg was "out of sync" and she noted the "huge" hematoma on R9's thigh and the "huge" scrape on her side. RN-A stated R9 had facial grimaces while staff were turning her stating,"She was weaker and having a lot of pain.". RN-A stated she did not check to see if one leg was shorter than the other but documented and reported off to the night shift her findings.

During interview on 8/25/16, at 6:27 a.m. NA-K stated she had worked the night of the 8/21/16. NA-K stated it was not reported to the NA's that R9 had an incident on the evening shift. NA-K stated R9's leg was swollen and sore and R9 asked for a pain med during the night. NA-K stated when she went to get R9 up in the morning with the EZ lift, R9 was crying and moaning in pain and could not transfer NA-K stated the

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nurse went in and gave R9 a pain medication and stated she was going to look at R9's leg in the morning. NA-K stated when she sat R9 up R9 complained of pain and started moaning and could not bear weight on her right leg. NA-K stated,"Her leg hurt really bad and she wouldn't put pressure on it, it was swollen at that time."

During interview on 8/25/16, at 6:40 a.m. NA-L stated she worked Monday (8/22/16) and R9 complained of pain when she was rolled over. NA-L also stated R9's leg was swollen and painful with movement and stated, "Anytime we rolled her she grimaced and complained of pain."

During interview on 8/25/16, at 9:37 a.m. NA-A stated she had worked the day shift 8/22/16. NA-A stated R9 was very restless and tired and would not open her eyes when her name was called which would be unusual for R9. NA-A stated she used the EZ stand as that is what the care plan indicated. NA-A stated R9 had a lot of pain with the transfers which was reported to the nurse. NA-A stated R9 was different than her normal, was not transferring well and kept repeating she had pain.

During interview on 8/25/16, at 11:53 a.m. LPN-B stated she was on duty when R9 was lowered to the floor. LPN-B stated she did not notice bruising, did a little range of motion and didn't think the right leg appeared to be fractured.

During interview on 8/26/16, at 8:35 a.m. RN-D stated R9 was having pain the morning of 8/22/16. RN-D stated R9 may have had more pain in the right lower extremity and stated,"She will have pain after a fall." RN-D stated NA-K had caught her at the end of the shift and reported R9

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had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. RN-D stated she gave R9 Tylenol in the morning before she got up.

During interview with the ADON on 8/24/16, at 11: 21 a.m. the ADON verified the physician should have been notified sooner of R9's increased pain and inability to transfer. The ADON verified the documentation identified R9 had been demonstrating pain, had swelling of her leg, and was restless from 8/21/16 to 8/23/16.

R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.

R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total assistance with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity, non pressure, initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.

Review of the Weekly Skin Reviews dated 8/9/16 and 8/23/16 indicated: Skin Intact. The skin reviews did not include evidence of other skin

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conditions including bruising.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification of the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was effective."

Further review of R38's medical record revealed no further mention of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture)

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rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care).

When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the state. RN-A further stated if bruising was occurring frequently or if a larger bruise or hematoma of unknown origin was identified and not explainable it would also be reported to the state. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to

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the elbow. RN-A stated the resident had a history of bruising but then verified that amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated for possible causes nor reported to the state agency when the bruising was identified on 8/10/16.

When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue was identified the nurse should investigate the source of the skin issue, notify the physician, complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the next shift. Nursing assistants (NA's) are also to let the charge nurse know as soon as they identify a new skin concern. Bruises are initially measured though nursing wouldn't necessarily measure again, but would monitor and indicate if the bruising was getting better or worse; wounds were measured weekly - bruises not necessarily unless there was a significant change. DON further stated if a large or suspicious bruise of unknown origin was not explainable, she would expect it to be reported immediately to the state. DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note,

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F 157	Continued From page 11 reported to the physician, administrator, and state agency when first identified on 8/10/16, and subsequently investigated and monitored by nursing. The policy titled Notification of Change in Resident Health Status last reviewed 11/11/15, included: The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is: (A) An accident which results in injury and has the potential for requiring physician intervention.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		9/23/16

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F 225	Continued From page 12 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse/neglect immediately to the designated State agency for 1 of 3 residents (R9) who sustained a spiral fracture of the right femur as a direct result of the care plan not being followed, and for 1 of 1 resident (R38) with significant bruising of unknown origin. Findings include: R9's admission record identified diagnoses including dementia and osteoporosis without current pathological fracture. R9's Minimum Data Set (MDS) significant change assessment dated 5/18/16, identified a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment. The Care Area Assessment (CAA) identified R9 at risk for falls and fall related injuries and the need for extensive	F 225	1. Facility has reported to state agency allegation of abuse/neglect for R9. Facility has reported to state agency bruise of unknown source for R38. 2. All residents had the potential to be affected by failure to report allegations immediately to the designated state agency. 3. Facility staff have been educated on reporting allegations of abuse to designated state agency. 4. DNS or designee will complete random audits of incidents for possible allegation of abuse and timely reporting to designated state agency weekly for four weeks and monthly for two months. Results will be communicated to facility QAPI committee.	

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assistance of 2 staff with transfers.

Review of R9's care plan revised 3/25/16, identified R9 had physical functioning ADL(activities of daily living) deficit with interventions that included R9 should have transfer assist of one staff and EZ stand lift or use 2 staff as needed (PRN). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified ADL's included transfers with the use of stand lift. The certified nursing assistant (NA) care sheet, updated 8/23/16, identified R9 required the EZ stand and 1 staff assist for transfers.

Review of R9's nursing notes dated 8/21/16, at 9:54 p.m. identified R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The incident report dated 8/21/16, under the IDT (interdisciplinary team) review and recommendations, identified care plan of 1 assist w/ (with) EZ stand for transfers not followed at time of fall. Education provided to nursing assistant (NA) assisting R9. R9 will remain an EZ stand for transfers. Further review of the nurses' notes identified R9 was transferred to the hospital 8/23/16 with a spiral fracture of the right femur.

During interview on 8/24/16, at 3:05 p.m. NA-H stated she transferred R9 on 8/21/16 when R9 was lowered to the floor. NA-H stated while she was transferring R9 between the commode and bed R9's right heel caught on the commode as she was turning her, and R9 "Fell into me and I slid her to the floor." NA-H stated staff were supposed to use the EZ stand lift to transfer R9. NA-H stated she used the transfer belt at times to transfer R9 between the commode or wheelchair

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and the bed. NA-H also stated she was aware the EZ stand was supposed to be used for R9 when transferring. NA-H stated "I screwed up big by not using it." When asked if there was any special reason she used the transfer belt and not the stand NA-H stated both lifts were in use and they were short staffed.

During interview with the director of nursing (DON) on 8/23/16, at 3:12 p.m. the DON verified NA-H had not followed R9's care plan for transfers and that no report had been filed with the State agency until today (8/23/16).

During interview on 8/25/16, at 11:53 a.m. licensed practical nurse (LPN)-B verified NA- H did not follow the care plan. LPN-B said NA-H had stated she'd thought she could just transfer R9 with the belt since R9 was right by the bed. NA-H then stated R9's foot had gotten caught on the commode when she was turning her and R9 had fallen towards NA-H.

R9's medical record documents lacked evidence an incident report had been submitted to the State agency until 8/23/16, 2 days after the incident occurred, and after R9 had been sent to the hospital and diagnosed with a spiral fracture. The incident report submitted on 8/23/16 indicated the report of maltreatment being reported was neglect.
R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.

R38's 14-day admission minimum data set (MDS) included a brief interview for mental status (BIMS)

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score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total assistance with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity, non pressure, initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following, "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note documented by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included, "Did request prn (as needed) Oxycodone at hs (hour of sleep) for left upper arm pain, that was effective."

Further review of R38's medical record revealed there was no mention of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a

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smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care).

Review of the Verification of Investigation report dated 8/18/16, completed by the executive director (ED) included the following: "Description of event/allegation: Bruising has occurred from an unknown cause. NH (nursing

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home) staff conclude bruising to left arm and left outer torso likely occurred from mechanical lift use for transfers. A progress note 8/10 by nursing indicates bruising first noted then. An SBAR was completed 8/17 with family and MD notification completed at that time.
Assessment of Resident: on 8/10 it was first noted resident presented with new bruising to left upper arm from shoulder down to elbow, cause was unknown. SBAR report was completed by NOC (night) nurse 8/17 in relation to left arm bruising as well as extended bruising to left outer torso region. Bruises are dark purple. Left arm is more swollen than the right. No hematoma or open skin found on assessment. Last fall in facility was 7/29/16.
Resident interview summary: Resident denies pan to bruised areas. Resident is unable to recall cause of bruising and was unaware of bruising until notified by staff.
Casual/contributing factors and observations: Resident had a fall on 7/29 from bed to floor. He is chronically on ASA 325 mg as only anticoagulation for MI prevention. Resident is dependent with all transfers which requires mechanical lift use and 1-2 person assist. Resident noted to have increased mental confusion since admission which is being monitored and documented by nursing. Resident has very fragile skin.
Recommendation/interventions taken to prevent reoccurrence: More careful handling reinforced to CNAs during ADLs and mechanical lift transfers r/t (related to) fragile skin and anticoagulation medicine.
Summary and outcome of investigative findings: Nursing, resident and family unable to determine exact time, location or occurrence in which bruising took place. There were no witnesses to

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an event. Only known event was from documented fall from self transfer on 7/29. Resident was evaluated and a skin examination took place on 8/17 by Dr [physician name]. No medication changes or further f/u (follow up) ordered by MD. "

When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the State. RN-A further stated if bruising was occurring frequently or if a larger bruise or hematoma of unknown origin was identified and not explainable would also be reported to the state. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but verified that this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated for possible causes, nor reported to the State agency when identified on 8/10/16.

When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue is identified the nurse should investigate the source of the skin issue, notify the physician,

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complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the next shift. Nursing assistants (NA's) are also to let the charge nurse know as soon as they identify a new skin concern. Bruises are initially measured though nursing wouldn't necessarily measure again, but would monitor and indicate if the bruising was getting better or worse; wounds were measured weekly - bruises not necessarily unless there was a significant change. DON further stated if a large or suspicious bruise of unknown origin was not explainable she would expect it to be reported immediately to the state. DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and state agency when first identified on 8/10/16, and subsequently investigated and monitored by nursing.

When interviewed on 8/26/16, at 9:04 a.m. the ED stated after investigating R38's left upper arm and left thoracic bruising deemed that it was probably from the full body lift used for this resident. The ED confirmed the facility did not report the significant bruising of unknown origin to the State agency prior too or after investigating the possible source of the bruising. Further, the ED was unaware if staff had been observed using the lift on R38 or training provided following the

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F 225	Continued From page 20 investigation into the bruising.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policy related to the immediate reporting of abuse/neglect to the administrator and the designated State agency for 1 of 3 residents (R9) who sustained a spiral fracture of the right femur as a direct result of the care plan not being followed, and 1 of 1 resident (R39) with significant bruising of unknown origin. In addition, the policy did not clearly define what would constitute mistreatment, abuse, neglect, injuries of unknown source or misappropriation of resident's property. Findings include: The policy titled, Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property dated 7/12/16, included the following: It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or	F 226	1. Administrator has been notified of alleged violations and will report results of investigation to state agencies as required. 2. All residents had the potential to be affected. 3. Facility staff have been educated on newly updated policy (updated 9/7/16) which includes examples of abuse and time lines on appropriate reporting for alleged violations to administrator and notification of state agencies. 4. DNS or designee will complete random audits of notification of administrator of alleged violations and reporting to state agencies for four weeks then monthly for two months. Results will be communicated to facility QAPI committee.	9/23/16

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State laws which involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations"), are reported immediately to the Executive Director (hereinafter "ED") of the center AND the Director of Rehabilitation (DOR) if it is Aegis employee. Such violations will also be reported to State agencies in accordance with existing State law. The ED will direct a thorough investigation of each such alleged violation unless there is a conflict of interest or the ED is implicated in the alleged violation, The ED is responsible to report the results of all investigations to the state agencies as required by state and federal law.

The policy further included under identification: Reporting of suspected alleged violations is required of every employee.

In addition, under the section titled Reporting, the policy included: Any employee who suspects an alleged violation shall immediately notify the ED AND DOR if it is an Aegis employee. The ED AND DOR shall also notify the appropriate state agency, in accordance with state law, as well as notify immediate management. The results of all investigations must be reported by the ED to the appropriate State agency, as required by State law, within five (5) working days of the alleged violation.

The policy did not clearly define what would constitute mistreatment, abuse, neglect, injuries of unknown source or misappropriation of resident's property.

R9's admission record identified diagnoses including dementia and osteoporosis without

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F 226	Continued From page 22 current pathological fracture. R9's Minimum Data Set (MDS) significant change assessment dated 5/18/16, identified a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment. The Care Area Assessment (CAA) identified R9 at risk for falls and fall related injuries and the need for extensive assistance of 2 staff with transfers. Review of R9's care plan revised 3/25/16, identified R9 had physical functioning ADL(activities of daily living) deficit with interventions that included R9 should have transfer assist of one staff and EZ stand lift or use 2 staff as needed (PRN). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified ADL's included transfers with the use of stand lift. The certified nursing assistant (NA) care sheet, updated 8/23/16, identified R9 required the EZ stand and 1 staff assist for transfers. Review of R9's nursing notes dated 8/21/16, at 9:54 p.m. identified R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed, The incident report dated 8/21/16, under the IDT (interdisciplinary team) review and recommendations, identified care plan of 1 assist w/ (with) EZ stand for transfers not followed at time of fall. Education provided to NA assisting R9. R9 will remain an EZ stand for transfers. Further review of the nurses notes identified R9 transferred to hospital 8/23/16 with a spiral fracture of the right femur. During interview on 8/24/16, at 3:05 p.m. nursing assistant (NA)-H stated she transferred R9 on	F 226		

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F 226	Continued From page 23	F 226		

8/21/16 when R9 was lowered to the floor. NA-H stated while she was transferring R9 between the commode and bed R9's right heel caught on the commode as she was turning her and R9, "Fell into me and I slid her to the floor." NA-H stated staff were supposed to use the EZ stand lift to transfer R9. NA-H stated she used the transfer belt at times to transfer R59 between the commode or wheelchair and the bed. NA-H also stated she was aware the EZ stand was supposed to be used for R9 when transferring. NA-H stated "I screwed up big by not using it." When asked if there was any special reason she used the transfer belt and not the stand NA-H she stated both lifts were in use and they were short staffed.

During interview with the director of nursing (DON) on 8/23/16, at 3:12 p.m. the DON verified NA-H did not follow R9's care plan for transfers and that no report had been filed with the state agency until 8/23/16.

During interview on 8/25/16, at 11:53 a.m. licensed practical nurse (LPN)-B verified NA- H did not follow the care plan. NA-H stated she thought she could just transfer R9 with the belt since R9 was right by the bed. NA-H then stated R9's foot got caught on the commode when she was turning her and R9 fell in a direction towards NA-H.

R9's medical record documents lacked evidence an incident report was submitted to the State agency until 8/23/16, 2 days after the incident occurred, and R9 was sent to the hospital and diagnosed with a spiral fracture. The incident report submitted on 8/23/16 indicated the report of maltreatment reported was neglect.

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R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.

R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total assistance with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity non pressure initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was effective."

Further review of R38's medical record did not include evidence of the bruising until a nursing

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progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy her at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click

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F 226	Continued From page 26 care). Review of the Verification of Investigation report dated 8/18/16, completed by the executive director (ED) included the following: Description of event/allegation: Bruising has occurred from an unknown cause. NH (nursing home) staff conclude bruising to left arm and left outer torso likely occurred from mechanical lift use for transfers. A progress note 8/10 by nursing indicates bruising first noted then. An SBAR was completed 8/17 with family and MD notification completed at that time. Assessment of Resident: on 8/10 it was first noted resident presented with new bruising to left upper arm from shoulder down to elbow, cause was unknown. SBAR report was completed by NOC (night) nurse 8/17 in relation to left arm bruising as well as extended bruising to left outer torso region. Bruises are dark purple. Left arm is more swollen than the right. No hematoma or open skin found on assessment. Last fall in facility was 7/29/16. Resident interview summary: Resident denies pan to bruised areas. Resident is unable to recall cause of bruising and was unaware of bruising until notified by staff. Casual/contributing factors and observations: Resident had a fall on 7/29 from bed to floor. He is chronically on ASA 325 mg as only anticoagulation for MI prevention. Resident is dependent with all transfers which requires mechanical lift use and 1-2 person assist. Resident noted to have increased mental confusion since admission which is being monitored and documented by nursing. Resident has very fragile skin. Recommendation/interventions taken to prevent reoccurrence: More careful handling reinforced	F 226		

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F 226	Continued From page 27 to CNAs during ADLs and mechanical lift transfers r/t (related to) fragile skin and anticoagulation medicine. Summary and outcome of investigative findings: Nursing, resident and family unable to determine exact time, location or occurrence in which bruising took place. There were no witnesses to an event. Only known event was from documented fall from self transfer on 7/29. Resident was evaluated and a skin examination took place on 8/17 by Dr [physician name]. No medication changes or further f/u (follow up) ordered by MD. When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the State. RN-A further stated if bruising was occurring frequently or if a larger bruise or hematoma of unknown origin was identified and not explainable would also be reported to the State. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but verified that this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated	F 226		

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F 226	Continued From page 28 for possible causes nor reported to the State agency when identified on 8/10/16. When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue is identified the nurse should investigate the source of the skin issue, notify the physician, complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the next shift. Nursing assistants (NA's) are also to let the charge nurse know as soon as they identify a new skin concern. DON further stated if a large or suspicious bruise of unknown origin was not explainable she would expect it to be reported immediately to the state. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and State agency when first identified on 8/10/16. When interviewed on 8/26/16, at 9:04 a.m. the ED stated after investigating R38's left upper arm and left thoracic bruising deemed that it was probably from the full body lift used for this resident. ED confirmed the facility did not report the significant bruising of unknown origin to the State agency prior too or after investigating the possible source of the bruising. Further, the ED was unaware if staff had been observed using the lift on R38 or training provided following the investigation into the bruising.	F 226		
F 282 SS=G	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	F 282		9/23/16

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F 282	Continued From page 29 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan related to transfers for 2 of 3 residents (R9 & R14) that resulted in actual harm for R9 when the resident was lowered to the floor and sustained a spiral femur fracture. The facility also failed to follow the care plan for activities of daily living (ADL's) for 1 of 3 residents (R12), and failed to monitor bruising for 1 of 1 resident (R38) reviewed for bruises of unknown origin. Findings include: R9 was admitted on 11/11/13. Review of R9's admission record identified diagnoses including dementia and osteoporosis without a current pathological fracture. R9's Minimum Data Set (MDS) significant change assessment dated 5/18/16, identified a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment. The Care Area Assessment (CAA) identified R9 at risk for falls and fall related injuries and the need for extensive assistance of 2 staff with transfers. Review of R9's care plan, revised 3/25/16, identified R9 had physical functioning ADL(activities of daily living) deficit with interventions to include R9 should have transfer assist of one staff and EZ stand lift or use 2 staff as needed (PRN). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified ADL's included transfers with the use of	F 282	1. Comprehensive care plan for residents R9, R14, R12 and R38 have been reviewed and revised to reflect residents current care needs. 2. All residents had potential to be affected. 3. Nursing staff have been educated on following care plan and CNA care sheets when providing resident care and monitoring bruising and nail care. 4. DNS or designee will complete random audits of following care plans/care sheets especially in regards to transferring and nail care and also monitoring of bruising weekly for four weeks then monthly for two months. Results will be communicated to facility QAPI committee.	

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stand lift. The certified nursing assistant (NA) care sheet, updated 8/23/16, identified R9 required the EZ stand and 1 staff assist for transfers.

Review of R9's nursing notes dated 8/21/16, at 9:54 p.m. identified R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The incident report dated 8/21/16, under the IDT (interdisciplinary team) review and recommendations, identified the care plan intervention of 1 assist w/ (with) EZ stand for transfers was not followed at the time of the fall. Education was provided to the NA assisting R9. R9 would remain an EZ stand for transfers. Further review of the nurses notes identified R9 transferred to the hospital 8/23/16 with a spiral fracture of the right femur.

During interview on 8/24/16, at 3:05 p.m. nursing assistant (NA)-H stated she transferred R9 on 8/21/16 when R9 was lowered to the floor. NA-H stated while she was transferring R9 between the commode and bed, R9's right heel caught on the commode as she was turning her and R9, "Fell into me and I slid her to the floor." NA-H stated staff were supposed to use the EZ stand lift to transfer R9. NA-H stated she used the transfer belt at times to transfer R59 between the commode or wheelchair and the bed. NA-H also stated she was aware the EZ stand was supposed to be used for R9 when transferring. NA-H stated, "I screwed up big by not using it." When asked if there was any special reason she used the transfer belt and not the stand NA-H she stated both lifts were in use and they were short-staffed.

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During interview with the director of nursing (DON) on 8/23/16, at 3:12 p.m., the DON verified NA-H did not follow R9's care plan for transfers.

During interview on 8/25/16, at 11:53 a.m. licensed practical nurse (LPN)-B verified NA- H did not follow the care plan. NA-H stated she thought she could just transfer R9 with the belt since R9 was right by the bed. NA-H then stated R9's foot got caught on the commode when she was turning her and R9 fell in a direction towards NA-H.

On 8/23/16, at 8:35 a.m. a note identified R9 was transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement.

R9 was transferred to the hospital at 10:50 a.m. on 8/23/16. A note from the emergency room (ER) visit dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.)identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.

During observation of cares on 8/22/16, at 4:58 p.m. R12 was observed in her room with long, jagged fingernails with dark brown substance underneath on both hands. R12 confirmed her

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nails were long and soiled and stated she needed to have her nails cut as they were too long. On 8/24/16, at 10:25 a.m. R12 was observed lying in bed. During the observation R12 was noted to continue to have long, jagged fingernails that were soiled underneath. R12 was further noted have a black/brown substance on her left thumb cuticle. R12 was interviewed during the observation and stated she needed to have her nails cut and that staff were going to do it sometime later in the day. On 8/24/16, at 4:00 p.m. R12's nails remained long, jagged and dirty with the black/brown substance remaining on the left thumb. R12 stated, staff had not come to her room to cut her nails and she wasn't sure when they would. On 8/25/16, at 7:31 a.m. R12 was observed in her room with nails remaining long, jagged and dirty with the black/.brown substance still present on the left thumb cuticle. R12 also stated her nails were too long and she needed them cut.

R12's quarterly minimum data set (MDS) assessment dated 8/10/16, included a Brief Interview for Mental Status (BIMS) assessment score of 11 indicating moderate cognitive impairment. The MDS also identified that R12 required extensive assistance with personal hygiene.

Review of R12's current resident care sheet identified R12 received a weekly bed bath on Friday mornings and had a splint to the left hand that was to be removed daily for hygiene. Review of R12's bath schedule for 8/19/16, indicated R12 had received a bath. The bath schedule identified staff were to PLEASE REMEMBER TO DO NAIL CARE!! The care plan revised 8/24/16, identified R12 required assistance of one staff

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with personal hygiene and nail care as needed (PRN). R12 also had an order to remove her palm guard in the A.M. with cares and complete hand hygiene which was indicated on the order review report dated 8/1/16-8/31/16.

When interviewed on 8/25/16, at 10:58 a.m. nursing assistant (NA)-A stated R12 got a bed bath on Fridays and staff were supposed to do her nails. She stated at times the nail cares did not get done because she received a bed bath instead of a tub bath. NA-A verified it did not look like R12's nail care had been completed with her bed bath on Friday. NA-B verified R12's nails were long, jagged and dirty. NA-B stated she would clean and trim R12's nails right away. NA-B also stated, "I tell my director that they need to do nails with a bed bath too and they don't always do it."

When interviewed on 8/25/16, at 11:00 a.m. the DON confirmed R12's care plan was not followed for nail care.

Review of the facility policy for Bed bath, last reviewed 12/7/15, included:
PROCEDURE: 14. Care of fingernails and toenails is part of the bath. Be certain nails are clean.

R14 was admitted with diagnoses including dementia, chronic obstructive pulmonary disease (COPD), depression, anxiety, and osteoporosis per the admission record face sheet.

The quarterly Minimum Data Set (MDS) assessment dated 7/16/16, indicated R14 required extensive assistance with toilet use, dressing, and personal hygiene, and supervision

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with one person physical assistance with bed mobility, transfer, and locomotion off the unit.

R14's care plan last revised 4/4/16, indicated a risk for falls. Interventions included: "Bed and W/C (wheelchair) alarms in place and checked daily for proper functioning." Review of the nursing assistant assignment sheet identified R14 utilized a bed and chair alarm for safety.

When interviewed on 8/24/16, at 3:20 p.m. nursing assistant (NA)-D stated R14 required assistance with transfers and toileting though would not always ask staff for assistance. NA-D stated that when R14 is in bed, she would often refuse cares as she just wanted to rest and not be disturbed. NA-D was unsure if the resident utilized an alarm when up in her w/c.

On 8/25/16, at 9:53 a.m. R14 was observed lying in bed crossways and appeared to be sleeping. The resident's head was positioned up against the wall with her legs/feet hanging off the exit side of the bed. R14's w/c was observed positioned next to the bed by the resident's feet with brakes off; no bed or chair alarm was visualized. At 10:05 a.m., NA-A stated R14 had probably transferred herself into bed. NA-A confirmed an alarm was not in place on the chair nor in the bed and should have been. NA-A stated she wasn't working on the resident's hall today but confirmed she had observed the resident utilizing a TABS clip alarm the day before while up in her w/c. NA-A searched R14's room for an alarm but was unable to locate one; NA-A stated the resident had been known to hide or throw away the alarms in the past. NA-A also attempted to reposition the resident in bed but the resident refused and yelled at NA-A to leave her alone. NA-A

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positioned R14's w/c next to the bed with the brakes locked then exited the room to alert the assistant director of nursing (ADON) that R14 was in need of a bed alarm. Shortly afterwards the ADON and NA-B entered R14's room with a sensor pad alarm. NA-B attempted to reposition R14 in bed while the ADON placed the sensor pad underneath the resident. The ADON was able to place the sensor alarm underneath the resident though R14 continued to refuse repositioning. NA-B stated the resident had refused morning cares earlier though was unsure who had assisted the resident in getting up for the day; NA-B was unsure if R14 had utilized an alarm earlier. NA-B searched R14's room and was unable to locate an alarm. The ADON confirmed the resident was to utilize an alarm when in her w/c and in bed per the plan of care.

R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.

R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total dependence with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity non pressure initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant

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findings. Skin assessment to be completed per Living Center Policy.

Review of the Weekly Skin Reviews dated 8/9/16 and 8/23/16 indicated: Skin Intact. The skin reviews did not include evidence of other skin conditions including bruising.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was effective."

Further review of R38's medical record did not include evidence of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on

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7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care).

When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the state. RN-A further stated if bruising was occurring frequently or if a larger bruise or hematoma of unknown

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F 282	Continued From page 38 origin was identified and not explainable would also be reported to the state. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but then did verify that this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated for possible causes nor reported to the state agency when identified on 8/10/16. When interviewed on 8/26/16, at 8:46 a.m. the DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, and reported to the physician per the plan of care when first identified on 8/10/16.	F 282		
F 309 SS=G	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	F 309		9/23/16

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F 309	Continued From page 39 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for pain and provide the necessary care and services for 1 of 3 residents (R9) in the sample who fell and sustained a femur fracture which resulted in actual harm, significant pain to R9, due to the facility's failure to assess and provide medical care in a timely manner as required. Also the facility failed to provide non pressure related skin care to 1 of 1 resident (R38) who had bruising of unknown origin and failed to ensure services were coordinated with the hospice agency for 1 of 1 residents (R28) receiving hospice care. Findings include: R9's admission record identified diagnosis including dementia and osteoporosis without current pathological fracture. R9 was observed on 8/22/16, at 5:24 p.m. sitting in her room in her wheelchair restless and moaning. An interview was attempted about her restlessness and moaning but R9 was unable to respond appropriately to questions. R9's significant change Minimum Data Set (MDS) assessment dated 5/18/16, identified R9 with a Brief Interview for Mental Status (BIMS) score of 00 indicating R9 had severe cognitive impairment. The Care Area Assessment (CAA) associated with the MDS identified R9 was at risk for falls and fall related injuries and required	F 309	1. Pain has been assessed and a plan is in place to manage pain for R9. Weekly skin inspections are in place for R38. Hospice provided contact information to R28 and will inform facility and R28 of visit schedule. 2. All residents had potential to be affected for pain management, weekly skin inspections. R28 is the only hospice resident in facility. 3. Licensed nursing staff have been educated on pain management, weekly skin inspections and coordination with hospice for care. 4. DNS or designee will complete random audits on pain management, weekly skin inspections and hospice communication weekly for four weeks then monthly for two months. Results will be communicated to facility QAPI committee.	

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F 309	Continued From page 40 extensive assistance of 2 staff with transfers. Review of R9's care plan revised 3/25/16, identified a physical functioning ADL (activities of daily living)/deficit with interventions that included transfers with assist of one staff and EZ stand lift (mechanical lift) or use 2 staff PRN (as needed). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified R9 required ADL assistance including transfers with stand lift. The certified nursing assistant (NA) care sheet updated 8/23/16, identified R9 requiring the EZ stand and 1 assist for transfers. During review of the nurses notes the following entries were noted: On 8/21/16, at 9:54 p.m. the note identified a change of condition situation had occurred. It was documented in the note that R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The note further identified minimal pain to right side and that R9 had reddish colored bruises on her right upper back under her right arm. The note also identified R9 stated she had pain "all over." On 8/22/16, at 8:53 a.m. a note identified that R9 had complained of right thigh pain at 6:00 a.m., and was unable to stand and required staff to use a full lift to transfer R9. On 8/22/16, at 4:31 p.m. a note identified R9 was complaining of pain to her right thigh while transferring in the EZ stand (mechanical lift device). On 8/22/16, at 10:28 p.m. a note identified R9	F 309		

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was having marked weakness when attempting to utilize the EZ stand and was not able to transfer safely. The note further indicated a full lift was used to transfer R9 back to bed at bedtime. R9 was noted to have a 6 centimeter (cm) red scrape below her left rib cage, on the outer aspect of her left chest. An addendum to the note at 11:27 p.m. clarified the scrape was on the right not the left. The note also identified R9 had a large light purple hematoma (bruise) that was raised and staff were able to cup their palm around the entire hematoma, The hematoma was identified as being firm to touch and measured 6 cm by 12 cm. R9's upper trochanter area was warm to touch. R9 was noticed to wince in pain with use of the lift as well as when rolled gently in bed.

On 8/23/16, at 8:35 a.m. a note identified R9 was transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement.

R9 was transferred to the hospital at 10:50 a.m. on 8/23/16. A note from the emergency room (ER) dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.)identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.

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During interview on 8/23/16, at 11:01 a.m. nursing assistant (NA)-I stated she did not get R9 up that morning. NA-I stated night shift got R9 up. NA-H stated when she transferred R9 to the wheel chair that day she used a full body lift rather than the EZ stand as R9 was sore on the right side.

During interview on 8/23/16, at 2:25 p.m. NA-J stated R9 utilized an EZ stand lift. NA-J stated the instructions to use the EZ stand lift was indicated on the NA care sheet that the aides carry with them.

During interview on 8/23/16, at 2:32 p.m., NA-D stated she was working the evening shift on 8/22/16. NA-D stated when she went to get R9 up out of her recliner with the EZ lift, R9 was leaning way to the left putting all of her weight on the left side, which was not usual for R9. NA-D stated R9 could not stand and was wincing with pain. NA-D stated at that time she notified the nurse immediately. NA-D stated that when she went in to put R9 to bed later that evening she again attempted to use the EZ lift and R9 would not put any weight on her right leg and was very pale and weak. NA-D stated staff then used a full body lift to get R9 into bed. NA-D stated she again told the nurse of R9's condition and the nurse then went to check on R9 and took vital signs (vs).

During interview on 8/24/16, at 11:21 a.m. the assistant director of nursing (ADON) stated that when R9 was unable to transfer her typical way, going from an EZ lift to a full body lift, the situation should have been looked into and warranted further investigation. The ADON stated,"This would be considered a change of

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condition for [R9] and she should have been reassessed." The ADON further stated she was not aware of R9's condition until they were going to send her to the hospital.

During interview on 8/24/16, at 3:05 p.m. NA-H stated she was transferring R9 from the commode to the bed on 8/21/16 and utilized a transfer belt. During the transfer R9 got her heel caught on the commode and when NA-H went to turn to get resident onto the bed, R9 fell into her and NA-H slid R9 to the floor. NA-H stated R9 grabbed her right leg and complained of pain.

During interview on 8/24/16, at 3:32 p.m. registered nurse (RN)-C stated she was working the day shift on 8/22/16. RN-C stated that at approximately 10:00 a.m. an aide told her R9 was having trouble keeping her feet on the EZ lift. RN-C stated that NA-A had reported to her that R9 was moaning and groaning a lot and complaining of her leg hurting.

During interview on 8/24/16, at 2:55 p.m. RN-A stated she had worked the evening of 8/22/16. RN-A stated she was told in report that R9 was transferring poorly during the day. RN-A stated the aides didn't feel safe transferring R9 with the EZ stand lift. RN-A stated staff asked her to go look at R9 which she did and she took R9's VS which were fine. RN-A further stated R9 was grimacing and appeared to be in a lot of pain when she was assisted into bed. RN-A also stated, at around 10:00 p.m. she notice R9's right leg was "out of sync" and she noted the "huge" hematoma on R9's thigh and the "huge" scrape on her side. RN-A stated R9 had facial grimaces while staff were turning her stating,"She was weaker and having a lot of pain.". RN-A stated

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she did not check to see if one leg was shorter than the other but documented and reported off to the night shift her findings.

During interview on 8/25/16, at 6:27 a.m. NA-K stated she had worked the night of the 8/21/16. NA-K stated it was not reported to the NA's that R9 had an incident on the evening shift. NA-K stated R9's leg was swollen and sore and R9 asked for a pain med during the night. NA-K stated when she went to get R9 up in the morning with the EZ lift, R9 was crying and moaning in pain and could not transfer NA-K stated the nurse went in and gave R9 a pain medication and stated she was going to look at R9's leg in the morning. NA-K stated when she sat R9 up R9 complained of pain and started moaning and could not bear weight on her right leg. NA-K stated,"Her leg hurt really bad and she wouldn't put pressure on it, it was swollen at that time."

During interview on 8/25/16, at 6:40 a.m. NA-L stated R9 complained of pain when she was rolled over. NA-L also stated R9's leg was swollen and painful with movement and stated, "Anytime we rolled her she grimaced and complained of pain."

During interview on 8/25/16, at 9:37 a.m. NA-A stated she had worked the day shift 8/22/16. NA-A stated R9 was very restless and tired and would not open her eyes when her name was called which would be unusual for R9. NA-A stated she used the EZ stand as that is what the care plan indicated. NA-A stated R9 had a lot of pain with the transfers which was reported to the nurse. NA-A stated R9 was different than her normal, was not transferring well and kept repeating she had pain.

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F 309	Continued From page 45 During interview on 8/25/16, at 11:30 a.m. R9's daughter (FA)-A stated she was at the hospital when her mother was transferred on 8/23/16. FA-A stated her mother was in so much pain it was "excruciating to watch." FA-A stated she had seen the x-ray of her mother's right leg and the surgeon had pointed out that the femur was broken at an angle and it was over-lapping 3 inches. The daughter also stated, "How did they not notice this, Her foot was sideways and 3 inches shorter? I don't know how they could even try to stand her up!" During interview on 8/25/16, at 11:53 a.m. LPN-B stated she was on duty when R9 was lowered to the floor. LPN-B stated she did not notice bruising, did a little range of motion and didn't think the right leg appeared to be fractured. During interview on 8/26/16, RN-D stated R9 was having pain the morning of 8/22/16. RN-D stated R9 may have had more pain in the right lower extremity and stated,"She will have pain after a fall." RN-D stated NA-K had caught her at the end of the shift and reported R9 had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. NA-D stated she gave R9 Tylenol in the morning before she got up. During interview with the ADON on 8/24/16, at 11: 21 a.m. the ADON verified the physician should have been notified sooner of R9's increased pain and inability to transfer. The ADON verified the documentation identified R9 had been demonstrating pain, had swelling of her leg, and was restless from 8/21/16 to 8/23/16.	F 309		

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The facility policy "Notification of Change in Resident Health Status" last reviewed 11/11/15, identified the facility would consult the residents physician, nurse practitioner or physician assistant when there was: (A) An accident which results in injury and had the potential for requiring physician intervention."
R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.

R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total dependence with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity non pressure initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.

Review of the Weekly Skin Reviews dated 8/9/16 and 8/23/16 indicated: Skin Intact. The skin reviews did not include evidence of other skin conditions including bruising.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and

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resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was effective."

Further review of R38's medical record did not include evidence of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12

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cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care).

Further review of the nursing progress notes dated 8/17/16 and 8/18/16 included charting on R38's left upper arm and left thoracic bruising. The medical record did not include monitoring of the bruising after 8/18/16.

Review of electronic treatment administration record (eTAR) dated 8/2016 did not include monitoring of R38's bruising.

When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but verified that

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this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift nor investigated for possible causes when identified on 8/10/16.

When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue is identified the nurse should investigate the source of the skin issue, notify the physician, complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the next shift. Nursing assistants (NA's) are also to let the charge nurse know as soon as they identify a new skin concern. Bruises are initially measured though nursing wouldn't necessarily measure again, but would monitor and indicate if the bruising was getting better or worse; wounds were measured weekly - bruises not necessarily unless there was a significant change. DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and state agency when first identified on 8/10/16, and subsequently investigated and monitored by nursing.

On 8/26/16, at 9:19 a.m. surveyor and DON

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observed R38 seated in w/c in room with 2 male visitors. DON attempted to remove R38's left arm from his long sleeve shirt but resident became resistive and thus attempt was stopped. Surveyor and DON were able to visualize a portion of the left arm bruising from below R38's left shoulder to the mid upper arm; dark reddish purple bruising noted that surrounded the posterior portion of the resident's upper arm and continued to extend towards the elbow. DON confirmed the bruising continued to be significant and would re-attempt to visualize and measure the bruising at a later time.

When interviewed on 8/26/16, at 9:37 a.m. the DON reviewed the nursing temporary problem communication book which identified R38's bruising dated 8/17/16. The form indicated that the shift responsible for documentation indicated "all". DON stated with this communication tool the expectation was that nursing would be monitoring and making a chart note daily related to the status of the bruising until healed. DON confirmed R38's bruising had not been monitored daily per the progress notes nor had been added to the eTAR for continued monitoring.

On 8/26/16, at approximately 1:00 p.m. the DON provided measurements of R38's left arm bruising; left posterior upper arm bruising measured 28 centimeters (cm) long x 16 cm wide. The bruising had increased from the last measurement on 8/17/16.

A policy on skin was requested but not provided.

R28's Significant Change Minimum Data Set (MDS) assessment dated 5/18/16 indicated she required total staff assistance in activities of daily

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living and had moderate cognitive impairment.

R28's care plan dated 6/2/16, identified that R28 received hospice centered care and staff were to coordinate the care plan with Hospice, keep the family informed of change in condition and to notify hospice of any change in condition or medication changes.

The hospice care plan dated 5/18/16 indicated a goal of pain management with weekly and as needed nurse visits and social work visits every 6 weeks and as needed.

During an observation on 8/24/16, at 9:07 a.m. R28 was sitting up in her recliner chair eating her breakfast. She was alert, neatly dressed and appeared comfortable.

During an interview on 8/24/16, at 9:25 a.m. R28 indicated she had not been on hospice care for long and did not know when they would be coming.

During an interview on 8/24/16, at 9:30 a.m. licensed practical nurse (LPN)-A indicated if there was something out of the norm she would talk to the ADON and she would assess whether to call hospice. LPN-A further indicated hospice visits weekly but that she did not know when they come.

During an interview on 8/24/16, at 9:51 a.m. the assistant director of nursing (ADON) verified there was no contact information regarding how and when to contact hospice in R28"s chart or on the bulletin board in the nursing office. She further verified they did not know when hospice was coming. They had asked for a schedule in

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F 309	Continued From page 52 the past but were not provided one. During a phone interview on 8/24/16, at 12:12 p.m. the triage hospice nurse indicated they would bring out contact information and stated, "They had to have removed it". She further verified that hospice would notify the facility on the day of the visit as there are patient schedule changes within the organization from day to day. The triage nurse indicated they tried to see R28 on Thursdays. During interview on 8/24/16, at 3:44 p.m. the administrator indicated that she would expect the hospice to let them know of the schedule and often the hospice would call the morning of the visit. She stated, "We do not have conversations with hospice unless we see them. They have lost all their staff". During interview on 8/24/16, at 3:51 p.m. the director of nursing (DON) indicated she would expect a visit schedule be provided by the hospice organization. In addition the DON verified there were no contact numbers for hospice posted on the chart or in the nursing office should hospice need to be contacted. A hospice policy was requested from the facility but was not provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		9/23/16

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F 312	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nail care for 1 of 3 residents (R12) reviewed for activities of daily living (ADL's). Findings include: R12 had been observed during cares on 8/22/16, at 4:58 p.m. R12 was observed in her room with long, jagged fingernails with dark brown substance underneath on both hands. R12 confirmed her nails were long and soiled and stated she needed to have her nails cut as they were too long. On 8/24/16, at 10:25 a.m. R12 was observed lying in bed. During the observation R12 was noted to continue to have long, jagged fingernails that were soiled underneath. R12 was further noted have a black/brown substance on her left thumb cuticle. R12 was interviewed during the observation and stated she needed to have her nails cut and that staff were going to do it sometime later in the day. On 8/24/16, at 4:00 p.m. R12's nails remained long, jagged and dirty with the black/brown substance remaining on the left thumb. R12 stated, staff had not come to her room to cut her nails and she wasn't sure when they would. On 8/25/16, at 7:31 a.m. R12 was observed in her room with nails remaining long, jagged and dirty with the black/.brown substance still present on the left thumb cuticle. R12 also stated her	F 312	1. Resident R12 had nail care provided. 2. All residents that are unable to carry out activities of daily living had potential to be affected. 3. Nursing staff have been educated on providing nail care with bathing and as needed. 4. DNS or designee will complete random audits on pain management, weekly skin inspections and hospice communication weekly for four weeks then monthly for two months. Results will be communicated to facility QAPI committee.	

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nails were too long and she needed them cut.

R12's quarterly minimum data set (MDS) assessment dated 8/10/16, included a Brief Interview for Mental Status (BIMS) assessment score of 11 indicating moderate cognitive impairment. The MDS also identified that R12 required extensive assistance with personal hygiene.

Review of R12's current resident care sheet identified R12 received a weekly bed bath on Friday mornings and had a splint to the left hand that was to be removed daily for hygiene. Review of R9's bath schedule for 8/19/16, indicated R12 had received a bath. The bath schedule identified staff were to PLEASE REMEMBER TO DO NAIL CARE!! The care plan revised 8/24/16, identified R12 required assistance of one staff with personal hygiene and nail care as needed (PRN). R12 also had an order to remove her palm guard in the A.M. with cares and complete hand hygiene which was indicated on the order review report dated 8/1/16-8/31/16.

When interviewed on 8/25/16, at 10:58 a.m. nursing assistant (NA)-A stated R12 got a bed bath on Fridays and staff were supposed to do her nails. She stated at times the nail cares did not get done because she received a bed bath instead of a tub bath. NA-A verified it did not look like R12's nail care had been completed with her bed bath on Friday. NA-B verified R12's nails were long, jagged and dirty. NA-B stated she would clean and trim R12's nails right away. NA-B also stated, "I tell my director that they need to do nails with a bed bath too and they don't always do it."

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F 312	Continued From page 55 When interviewed on 8/25/16, at 11:00 a.m. the director of nursing (DON) confirmed R12 should have had nail care provided per her plan of care. The DON further confirmed the NA's were responsible for nail care when resident's received their bath regardless if a bed bath, shower or tub bath is given. Review of the facility policy for Bed bath, last reviewed 12/7/15, included: PROCEDURE: 14. Care of fingernails and toenails is part of the bath. Be certain nails are clean.	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review ,the facility failed to provide services in a manner that promoted safety for 2 of 3 residents (R9 & R14) in the sample who were identified at risk for falls. The failure of the facility to provide services in a safe manner resulted in harm to R9 who sustained a right femur fracture. Findings include: R9's admission record identified diagnoses	F 323	1. Resident R9 uses stand lift for all transfers. resident R14 has alarms in place on bed and wheelchair. 2. All residents who use mechanical lifts or alarms had potential to be affected. 3. Nursing staff have been educated providing services in a manner to prevent accidents. 4. DNS or designee will complete random audits on lift use and alarm use. Weekly for four weeks then monthly for two	9/23/16

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F 323	Continued From page 56 including dementia and osteoporosis without current pathological fracture. R9 was observed on 8/22/16, at 5:24 p.m. sitting in her room in her wheelchair restless and moaning. An interview was attempted about her restlessness and moaning but R9 was unable to respond appropriately to questions. R9's significant change Minimum Data Set (MDS) assessment dated 5/18/16, identified R9 with a Brief Interview for Mental Status (BIMS) score of 00 indicating R9 had severe cognitive impairment. The Care Area Assessment (CAA) associated with the MDS identified R9 was at risk for falls and fall related injuries and required extensive assistance of 2 staff with transfers. Review of R9's care plan revised 3/25/16, identified a physical functioning ADL/deficit with interventions that included transfers with assist of one staff and EZ stand lift or use 2 staff PRN (as needed). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified R9 required ADL assistance including transfers with stand lift. The certified nursing assistant (NA) care sheet updated 8/23/16, identified R9 requiring the EZ stand and 1 assist for transfers. During review of the nurses notes the following entries were noted: On 8/21/16, at 9:54 p.m. the note identified a change of condition situation had occurred. It was documented in the note that R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The note further identified minimal pain to right side and that R9 had reddish colored bruises	F 323	months. Results will be reported to facility QAPI committee.	

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	245319	A. BUILDING _____ B. WING _____	08/26/2016

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on her right upper back under her right arm. The note also identified R9 stated she had pain "all over."

On 8/22/16, at 8:53 a.m. a note identified that R9 had complained of right thigh pain at 6:00 a.m., and was unable to stand and required staff to use a full lift to transfer R9.

On 8/22/16, at 4:31 p.m. a note identified R9 was complaining of pain to her right thigh while transferring in the EZ stand (mechanical lift device).

On 8/22/16, at 10:28 p.m. a note identified R9 was having marked weakness when attempting to utilize the EZ stand and was not able to transfer safely. The note further indicated a full lift was used to get R9 back to bed at bedtime. R9 was noted to have a 6 centimeter (cm) red scrape below her left rib cage, on outer aspect of left chest. An addendum to the note on 11:27 p.m. clarified the scrape was on the right not the left. The note also identified R9 had a large light purple hematoma (bruise) that was raised and staff were able to cup their palm around the entire hematoma, The hematoma was identified as being firm to touch and measured 6 cm by 12 cm. R9's upper trochanter area was warm to touch. R9 was noticed to wince in pain with use of the lift as well as when rolled gently in bed.

On 8/23/16, at 8:35 a.m. R9 a note identified R9 was transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement.

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R9 was transferred to the hospital at 10:50 a.m.,. A note from the emergency room (ER) dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.) identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.

During interview on 8/23/16, at 2:25 p.m. NA-J stated R9 utilized an EZ stand lift. NA-J stated the instructions to use the EZ stand lift was indicated on the NA care sheet that the aides carry with them.

During interview on 8/23/16, at 2:32 p.m., NA-D stated she was working the evening shift on 8/22/16. NA-D stated when she went to get R9 up out of her recliner with the EZ lift, R9 was leaning way to the left putting all of her weight on the left side, which was not usual for R9. NA-D stated R9 could not stand and was wincing with pain. NA-D stated at that time she notified the nurse immediately. NA-D stated that when she went in to put R9 to bed later that evening she again attempted to use the EZ lift and R9 would not put any weight on her right leg and was very pale and weak. NA-D stated staff then used a full body lift to get R9 into bed. NA-D stated she again told the nurse of R9's condition and the nurse then went to check on R9 and took vital signs (vs).

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During interview on 8/24/16, at 11:21 a.m. the assistant director of nursing (ADON) stated that when R9 was unable to transfer her typical way, going from an EZ lift to a full body lift, the situation should have been looked into and warranted further investigation. The ADON stated,"This would be considered a change of condition for [R9] and she should have been reassessed." The ADON further stated she was not aware of R9's condition until they were going to send her to the hospital.

During interview on 8/24/16, at 3:05 p.m. NA-H stated she was transferring R9 from the commode to the bed on 8/21/16 and utilized a transfer belt. During the transfer R9 got her heel caught on the commode and when NA-H went to turn to get resident onto the bed, R9 fell into her and NA-H slid R9 to the floor. NA-H stated R9 grabbed her right leg and complained of pain.

During interview on 8/24/16, at 2:55 p.m. RN-A stated she had worked the evening of 8/22/16. RN-A stated she was told in report that R9 was transferring poorly during the day. RN-A stated the aides didn't feel safe transferring R9 with the EZ stand lift. RN-A stated staff asked her to go look at R9 which she did and she took R9's vital signs. which were fine. RN-A further stated R9 was grimacing and appeared to be in a lot of pain when she was assisted into bed. RN-A also stated, at around 10:00 p.m. she notice R9's right leg was "out of sync" and she noted the "huge" hematoma on R9's thigh and the "huge" scrape on her side. RN-A stated R9 had facial grimaces while staff were turning her stating,"She was weaker and having a lot of pain.". RN-A stated she did not check to see if one leg was shorter than the other but documented and reported off to

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the night shift her findings.

During interview on 8/25/16, at 6:27 a.m. NA-K stated she had worked the night of the 8/21/16. NA-K stated it was not reported to the NA's that R9 had an incident on the evening shift. NA-K stated R9's leg was swollen and sore and R9 asked for a pain med during the night. NA-K stated when she went to get R9 up in the morning with the EZ lift, R9 was crying and moaning in pain and could not transfer NA-K stated the nurse went in and gave R9 a pain medication and stated she was going to look at R9's leg in the morning. NA-K stated when she sat R9 up R9 complained of pain and started moaning and could not bear weight on her right leg. NA-K stated,"Her leg hurt really bad and she wouldn't put pressure on it, it was swollen at that time."

During interview on 8/25/16, at 9:37 a.m. NA-A stated she had worked the day shift 8/22/16. NA-A stated R9 was very restless and tired and would not open her eyes when her name was called which would be unusual for R9. NA-A stated she used the EZ stand as that is what the care plan indicated. NA-A stated R9 had a lot of pain with the transfers which was reported to the nurse. NA-A stated R9 was different than her normal, was not transferring well and kept repeating she had pain.

During interview on 8/25/16, at 11:30 a.m. R9's daughter (FA)-A stated she was at the hospital when her mother was transferred on 8/23/16. FA-A stated her mother was in so much pain it was "excruciating to watch." FA-A stated she had seen the x-ray of her mothers right leg and the surgeon had pointed out that the femur was broken at an angle and it was over-lapping 3

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inches. The daughter also stated, "How did they not notice this, Her foot was sideways and 3 inches shorter? I don't know how they could even try to stand her up!"

During interview on 8/25/16, at 11:53 a.m. LPN-B stated she was on duty when R9 was lowered to the floor. LPN-B stated she did not notice bruising, did a little range of motion and didn't think the right leg appeared to be fractured.

During interview on 8/26/16, RN-D stated R9 was having pain the morning of 8/22/16. RN-D stated R9 may have had more pain in the right lower extremity and stated,"She will have pain after a fall." RN-D stated NA-K had caught her at the end of the shift and reported R9 had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. NA-D stated she gave R9 Tylenol in the morning before she got up.

The facility policy "Notification of Change in Resident Health Status" last reviewed 11/11/15, identified the facility would consult the residents physician, nurse practitioner or physician assistant when there was: (A) An accident which results in injury and had the potential for requiring physician intervention."

R14 was admitted with diagnoses including dementia, chronic obstructive pulmonary disease (CODP), depression, anxiety, and osteoporosis per the admission record face sheet.

The quarterly Minimum Data Set (MDS) assessment dated 7/16/16, indicated R14 required extensive assistance with toilet use,

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dressing, and personal hygiene, and supervision with one person physical assistance with bed mobility, transfer, and locomotion off the unit.

R14's care plan last revised 4/4/16, indicated a risk for falls. Interventions included: "Bed and W/C (wheelchair) alarms in place and checked daily for proper functioning." Review of the nursing assistant assignment sheet identified R14 utilized a bed and chair alarm for safety.

When interviewed on 8/24/16, at 3:20 p.m. nursing assistant (NA)-D stated R14 required assistance with transfers and toileting though would not always ask staff for assistance. NA-D stated that when R14 is in bed, she would often refuse cares as she just wanted to rest and not be disturbed. NA-D was unsure if the resident utilized an alarm when up in her w/c.

On 8/25/16, at 9:53 a.m. R14 was observed lying in bed crossways and appeared to be sleeping. The resident's head was positioned up against the wall with her legs/feet hanging off the exit side of the bed. R14's w/c was observed positioned next to the bed by the resident's feet with brakes off; no bed or chair alarm was visualized. At 10:05 a.m., NA-A stated R14 had probably transferred herself into bed. NA-A confirmed an alarm was not in place on the chair nor in the bed and should have been. NA-A stated she wasn't working on the resident's hall today but confirmed she had observed the resident utilizing a TABS clip alarm the day before while up in her w/c. NA-A searched R14's room for an alarm but was unable to locate one; NA-A stated the resident had been known to hide or throw away the alarms in the past. NA-A also attempted to reposition the resident in bed but the resident refused and

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F 323	Continued From page 63 yelled at NA-A to leave her alone. NA-A positioned R14's w/c next to the bed with the brakes locked then exited the room to alert the assistant director of nursing (ADON) that R14 was in need of a bed alarm. Shortly afterwards the ADON and NA-B entered R14's room with a sensor pad alarm. NA-B attempted to reposition R14 in bed while the ADON placed the sensor pad underneath the resident. The ADON was able to place the sensor alarm underneath the resident though R14 continued to refuse repositioning. NA-B stated the resident had refused morning cares earlier though was unsure who had assisted the resident in getting up for the day; NA-B was unsure if R14 had utilized an alarm earlier. NA-B searched R14's room and was unable to locate an alarm. The ADON confirmed the resident was to utilize an alarm when in her w/c and in bed per the plan of care.	F 323		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		9/23/16

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F 431	Continued From page 64 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were appropriately secured at all times during medication passes for 1 of 2 residents (R60). Findings include: R60 had physician orders dated 8/12/16, for insulin aspart, five units to be injected before meals and insulin aspart on a sliding scale. The orders indicated that when R60's blood sugar was between 150 milligrams per deciliter (mg/dL) and 200 mg/dL, two additional units of aspart were to be administered. During observations on 8/24/16, at 5:05 p.m., the 100 wing medication cart was positioned outside of room 106. Observations at that time revealed registered nurse (RN)-A removed R60's Novolog	F 431	1. Facility ensures medications are appropriately secured during medication pass. 2. All residents had the potential to be affected by medication left on cart. 3. Any staff who would administer medications have been educated on properly securing medication during medication pass. 4. DNS or designee will complete random audits on properly securing medication during medication pass weekly for four weeks then monthly for two months. Results will be reported to facility QAPI committee.	

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(same as aspart) insulin pen from the medication cart drawer, wasted two units of insulin, dialed the pen to five units and placed the insulin pen on top of the medication cart. RN-A stated the routine was to set up the insulin and leave it on top of the medication cart while RN-A checked R60's blood sugar. Observation at that time revealed RN-A walked away from the medication cart to room 112 located near the end of the 100 wing hallway. RN-A then checked R60's blood sugar in room 112. When the blood sugar check was completed, RN-A returned to the medication cart, still positioned outside of room 106. Observations at that time revealed two residents and two visitors were standing at room 109 near the medication cart. RN-A removed the insulin pen, dialed two more units to equal seven units, and returned to administer the insulin to R60.

During interview on 8/24/16, at 6:00 p.m., the director of nursing verified she expected medications to be locked in the medication cart and not left unattended on top of the medication cart.

Document review of facility's Medication Administration-Preparation and General Guidelines policy dated 6/2015, page 4 #16 indicated that, "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by."

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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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 8/23/2016, Golden Livingcenter - La Crescent was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/2016

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

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K 000	Continued From page 1 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. The Golden Livingcenter - La Crescent, is a 1-story building with no basement. The facility was constructed in 1968 and was determined to be of Type II(000) construction.	K 000		
K 067 SS=F	The facility is fully sprinklered and has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 44 beds and had a census of 37 beds at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A,	K 067		9/23/16

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K 067	Continued From page 2 19.5.2.2 This STANDARD is not met as evidenced by: Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observations and staff interviews, the facility's general ventilating and air conditioning system (HVAC) is not installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all 41 residents. Findings include: On facility tour between 10:00 AM and 12:30 noon on 08/23/2016, observation and interview with the facility Maintenance Director (MO), revealed that the ventilation system in the 100 and 200 wings, utilizes the egress corridor as the supply air for the resident rooms. This deficient practice was confirmed by the facility Maintenance Director (MO) at the time of discovery.	K 067	1. Waiver request for this deficiency has been submitted.	

Name of Facility **2000 CODE**

Golden LivingCenter-La Crescent

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067	A waiver is requested for K067 for the following reasons: A) There will be no adverse effects on the health and safety of the facility's residents and staff since: 1. The building is equipped with an approved corridor smoke detection system 2. The building has automatic shut down of ventilation fans/HVAC system upon detection of smoke or activation of the building fire alarm system. 3. Annual service and maintenance contracts exist to service all the facility's fire protection systems (for example: fire alarms, sprinkler system, portable extinguishers). 4. The building fire alarm system is monitored to provide automatic fire department notification. 5. Fire safety training is provided for employees on an annual basis and during orientation for new hires. 6. Fire drills are conducted at least quarterly on each shift. 7. The facility is protected by a supervised automatic sprinkler system. B) Compliance with this provision would impose an unreasonable hardship on the facility since: 1. It would cost an estimated $242,168.00 to upgrade the HVAC system to comply with the NPPA 90A. THis firgure does not include upgrading the electrical system to accommodate the HVAC equipment. C) This tag was previously sited and recommendations were reviewed. A waiver for this tag is requested.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* Thomas Linhoff 12424	Title Fire Safety Supervisor	Office State Fire Marshal Division	Date 10/05/2016

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 12, 2016

Ms. Abby Rand, Administrator
Golden Livingcenter - La Crescent
101 South Hill Street
La Crescent, MN 55947

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5319025

Dear Ms. Rand:

The above facility was surveyed on August 22, 2016 through August 26, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the 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 me.

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	08/26/2016

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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 August 22, 23, 24, 25, & 26, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		9/23/16

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the physician of pain/injury following a fall for 1 of 3 (R9) who had a fall that resulted in harm evidenced by pain related to a fracture of the femur for R9. Further, the facility failed to notify the physician of significant bruising for 1 of 1 resident (R38) with significant bruising of unknown origin when initially identified. Findings include: Review of R9's admission record identified diagnoses including dementia and osteoporosis without current pathological fracture. R9 was observed on 8/22/16, at 5:24 p.m. sitting in her room in her wheelchair. She was restless and moaning. An interview was attempted about her restlessness and moaning but R9 was unable to respond appropriately to questions. R9's significant change Minimum Data Set (MDS) assessment dated 5/18/16, identified R9 with a Brief Interview for Mental Status (BIMS) score of 00 indicating R9 had severe cognitive impairment. The Care Area Assessment (CAA) associated with the MDS identified R9 was at risk for falls and fall related injuries and required extensive assistance of 2 staff with transfers. During review of the nurses notes the following entries were noted: On 8/21/16, at 9:54 p.m. the note identified a	2 265	Corrected	

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2 265	Continued From page 4	2 265		

change of condition situation had occurred. It was documented in the note that R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The note further identified minimal pain to the right side and that R9 had reddish colored bruises on her right upper back under her right arm. The note also identified R9 stated she had pain "all over."

On 8/22/16, at 8:53 a.m. a note identified that R9 had complained of right thigh pain at 6:00 a.m., and was unable to stand and required staff to use a full lift to transfer R9.

On 8/22/16, at 4:31 p.m. a note identified R9 was complaining of pain to her right thigh while transferring in the EZ stand (mechanical lift device).

On 8/22/16, at 10:28 p.m. a note identified R9 was having marked weakness when attempting to utilize the EZ stand and was not able to transfer safely. The note further indicated a full lift was used to transfer R9 back to bed at bedtime. R9 was noted to have a 6 centimeter (cm) red scrape below her left rib cage, on the outer aspect of her left chest. An addendum to the note on 11:27 p.m. clarified the scrape was on the right not the left. The note also identified R9 had a large light purple hematoma (bruise) that was raised and staff were able to cup their palm around the entire hematoma, The hematoma was identified as being firm to touch and measured 6 cm by 12 cm. R9's upper trochanter area was warm to touch. R9 was noticed to wince in pain with use of the lift as well as when rolled gently in bed.

On 8/23/16, at 8:35 a.m. a note identified R9 was

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2 265	Continued From page 5	2 265		

transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement.

R9 was transferred to the hospital at 10:50 a.m. on 8/23/16. A note from the emergency room (ER) dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.)identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.

During interview on 8/23/16, at 11:01 a.m. nursing assistant (NA)-I stated she did not get R9 up that morning. NA-I stated night shift got R9 up. NA-H stated when she transferred R9 to the wheel chair that day she used a full body lift rather than the EZ stand as R9 was sore on the right side.

During interview on 8/23/16, at 2:25 p.m. NA-J stated R9 utilized an EZ stand lift. NA-J stated the instructions to use the EZ stand lift were indicated on the NA care sheet that the aides carry with them.

During interview on 8/23/16, at 2:32 p.m., NA-D stated she was working the evening shift on 8/22/16. NA-D stated when she went to get R9 up out of her recliner with the EZ lift, R9 was leaning way to the left putting all of her weight on the left side, which was not usual for R9. NA-D

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2 265	Continued From page 6	2 265		

stated R9 could not stand and was wincing with pain. NA-D stated at that time she notified the nurse immediately. NA-D stated that when she went in to put R9 to bed later that evening she again attempted to use the EZ lift and R9 would not put any weight on her right leg and was very pale and weak. NA-D stated staff then used a full body lift to get R9 into bed. NA-D stated she again told the nurse of R9's condition and the nurse then went to check on R9 and took vital signs (VS).

During interview on 8/24/16, at 11:21 a.m. the assistant director of nursing (ADON) stated that when R9 was unable to transfer her typical way, going from an EZ lift to a full body lift, the situation should have been looked into and warranted further investigation. The ADON stated, "This would be considered a change of condition for R9."

During interview on 8/24/16, at 3:05 p.m. NA-H stated she was transferring R9 from the commode to the bed on 8/21/16 and utilized a transfer belt. During the transfer R9 got her heel caught on the commode and when NA-H went to turn to get the resident onto the bed, R9 fell into her and NA-H slid R9 to the floor. NA-H stated R9 grabbed her right leg and complained of pain.

During interview on 8/24/16, at 3:32 p.m. registered nurse (RN)-C stated she was working the day shift on 8/22/16. RN-C stated that at approximately 10:00 a.m. an aide told her R9 was having trouble keeping her feet on the EZ lift. RN-C stated that NA-A had reported to her that R9 was moaning and groaning a lot and complaining of her leg hurting. During interview on 8/24/16, at 2:55 p.m. RN-A stated she had worked the evening of 8/22/16. RN-A stated she

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2 265	Continued From page 7	2 265		

was told in report that R9 was transferring poorly during the day. RN-A stated the aides didn't feel safe transferring R9 with the EZ stand lift. RN-A stated staff asked her to go look at R9 which she did and she took R9's v.s. which were fine. RN-A further stated R9 was grimacing and appeared to be in a lot of pain when she was assisted into bed. RN-A also stated, at around 10:00 p.m. she notice R9's right leg was "out of sync" and she noted the "huge" hematoma on R9's thigh and the "huge" scrape on her side. RN-A stated R9 had facial grimaces while staff were turning her stating,"She was weaker and having a lot of pain.". RN-A stated she did not check to see if one leg was shorter than the other but documented and reported off to the night shift her findings.

During interview on 8/25/16, at 6:27 a.m. NA-K stated she had worked the night of the 8/21/16. NA-K stated it was not reported to the NA's that R9 had an incident on the evening shift. NA-K stated R9's leg was swollen and sore and R9 asked for a pain med during the night. NA-K stated when she went to get R9 up in the morning with the EZ lift, R9 was crying and moaning in pain and could not transfer NA-K stated the nurse went in and gave R9 a pain medication and stated she was going to look at R9's leg in the morning. NA-K stated when she sat R9 up R9 complained of pain and started moaning and could not bear weight on her right leg. NA-K stated,"Her leg hurt really bad and she wouldn't put pressure on it, it was swollen at that time."

During interview on 8/25/16, at 6:40 a.m. NA-L stated she worked Monday (8/22/16) and R9 complained of pain when she was rolled over. NA-L also stated R9's leg was swollen and painful with movement and stated, "Anytime we rolled

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2 265	Continued From page 8 her she grimaced and complained of pain." During interview on 8/25/16, at 9:37 a.m. NA-A stated she had worked the day shift 8/22/16. NA-A stated R9 was very restless and tired and would not open her eyes when her name was called which would be unusual for R9. NA-A stated she used the EZ stand as that is what the care plan indicated. NA-A stated R9 had a lot of pain with the transfers which was reported to the nurse. NA-A stated R9 was different than her normal, was not transferring well and kept repeating she had pain. During interview on 8/25/16, at 11:53 a.m. LPN-B stated she was on duty when R9 was lowered to the floor. LPN-B stated she did not notice bruising, did a little range of motion and didn't think the right leg appeared to be fractured. During interview on 8/26/16, at 8:35 a.m. RN-D stated R9 was having pain the morning of 8/22/16. RN-D stated R9 may have had more pain in the right lower extremity and stated,"She will have pain after a fall." RN-D stated NA-K had caught her at the end of the shift and reported R9 had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. RN-D stated she gave R9 Tylenol in the morning before she got up. During interview with the ADON on 8/24/16, at 11: 21 a.m. the ADON verified the physician should have been notified sooner of R9's increased pain and inability to transfer. The ADON verified the documentation identified R9 had been demonstrating pain, had swelling of her leg, and was restless from 8/21/16 to 8/23/16.	2 265		

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2 265	Continued From page 9	2 265		

R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.

R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total assistance with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity, non pressure, initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.

Review of the Weekly Skin Reviews dated 8/9/16 and 8/23/16 indicated: Skin Intact. The skin reviews did not include evidence of other skin conditions including bruising.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification of the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was

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2 265	Continued From page 10 effective." Further review of R38's medical record revealed no further mention of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This	2 265		

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2 265	Continued From page 11	2 265		

writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care).

When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the state. RN-A further stated if bruising was occurring frequently or if a larger bruise or hematoma of unknown origin was identified and not explainable it would also be reported to the state. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but then verified that amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated for possible causes nor reported to the state agency when the bruising was identified on 8/10/16.

When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue was identified the nurse should investigate the source of the skin issue, notify the physician, complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the

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2 265	Continued From page 12 next shift. Nursing assistants (NA's) are also to let the charge nurse know as soon as they identify a new skin concern. Bruises are initially measured though nursing wouldn't necessarily measure again, but would monitor and indicate if the bruising was getting better or worse; wounds were measured weekly - bruises not necessarily unless there was a significant change. DON further stated if a large or suspicious bruise of unknown origin was not explainable, she would expect it to be reported immediately to the state. DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and state agency when first identified on 8/10/16, and subsequently investigated and monitored by nursing. The policy titled Notification of Change in Resident Health Status last reviewed 11/11/15, included: The center will consult the resident's physician, nurse practitioner or physician assistant, and if known notify the resident's legal representative or an interested family member when there is: (A) An accident which results in injury and has the potential for requiring physician intervention. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could review and/or revise policies and procedures related to	2 265		

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2 265	Continued From page 13 notification of physician with significant changes in resident status and educate staff related to the changes. The Quality Assurance Committee could conduct audits periodically for compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan related to transfers for 2 of 3 residents (R9 & R14) that resulted in actual harm for R9 when the resident was lowered to the floor and sustained a spiral femur fracture. The facility also failed to follow the care plan for activities of daily living (ADL's) for 1 of 3 residents (R12), and failed to monitor bruising for 1 of 1 resident (R38) reviewed for bruises of unknown origin. Findings include: R9 was admitted on 11/11/13. Review of R9's admission record identified diagnoses including dementia and osteoporosis without a current pathological fracture. R9's Minimum Data Set (MDS) significant change	2 565	Corrected	9/23/16

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assessment dated 5/18/16, identified a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment. The Care Area Assessment (CAA) identified R9 at risk for falls and fall related injuries and the need for extensive assistance of 2 staff with transfers.

Review of R9's care plan, revised 3/25/16, identified R9 had physical functioning ADL(activities of daily living) deficit with interventions to include R9 should have transfer assist of one staff and EZ stand lift or use 2 staff as needed (PRN). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified ADL's included transfers with the use of stand lift. The certified nursing assistant (NA) care sheet, updated 8/23/16, identified R9 required the EZ stand and 1 staff assist for transfers.

Review of R9's nursing notes dated 8/21/16, at 9:54 p.m. identified R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The incident report dated 8/21/16, under the IDT (interdisciplinary team) review and recommendations, identified the care plan intervention of 1 assist w/ (with) EZ stand for transfers was not followed at the time of the fall. Education was provided to the NA assisting R9. R9 would remain an EZ stand for transfers. Further review of the nurses notes identified R9 transferred to the hospital 8/23/16 with a spiral fracture of the right femur.

During interview on 8/24/16, at 3:05 p.m. nursing assistant (NA)-H stated she transferred R9 on 8/21/16 when R9 was lowered to the floor. NA-H stated while she was transferring R9 between the commode and bed, R9's right heel caught on

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2 565	Continued From page 15 the commode as she was turning her and R9, "Fell into me and I slid her to the floor." NA-H stated staff were supposed to use the EZ stand lift to transfer R9. NA-H stated she used the transfer belt at times to transfer R59 between the commode or wheelchair and the bed. NA-H also stated she was aware the EZ stand was supposed to be used for R9 when transferring. NA-H stated, "I screwed up big by not using it." When asked if there was any special reason she used the transfer belt and not the stand NA-H she stated both lifts were in use and they were short-staffed. During interview with the director of nursing (DON) on 8/23/16, at 3:12 p.m., the DON verified NA-H did not follow R9's care plan for transfers. During interview on 8/25/16, at 11:53 a.m. licensed practical nurse (LPN)-B verified NA- H did not follow the care plan. NA-H stated she thought she could just transfer R9 with the belt since R9 was right by the bed. NA-H then stated R9's foot got caught on the commode when she was turning her and R9 fell in a direction towards NA-H. On 8/23/16, at 8:35 a.m. a note identified R9 was transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement. R9 was transferred to the hospital at 10:50 a.m. on 8/23/16. A note from the emergency room (ER) visit dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had	2 565		

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2 565	Continued From page 16	2 565		

contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.)identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.

During observation of cares on 8/22/16, at 4:58 p.m. R12 was observed in her room with long, jagged fingernails with dark brown substance underneath on both hands. R12 confirmed her nails were long and soiled and stated she needed to have her nails cut as they were too long. On 8/24/16, at 10:25 a.m. R12 was observed lying in bed. During the observation R12 was noted to continue to have long, jagged fingernails that were soiled underneath. R12 was further noted have a black/brown substance on her left thumb cuticle. R12 was interviewed during the observation and stated she needed to have her nails cut and that staff were going to do it sometime later in the day. On 8/24/16, at 4:00 p.m. R12's nails remained long, jagged and dirty with the black/brown substance remaining on the left thumb. R12 stated, staff had not come to her room to cut her nails and she wasn't sure when they would. On 8/25/16, at 7:31 a.m. R12 was observed in her room with nails remaining long, jagged and dirty with the black/.brown substance still present on the left thumb cuticle. R12 also stated her nails were too long and she needed them cut.

R12's quarterly minimum data set (MDS) assessment dated 8/10/16, included a Brief Interview for Mental Status (BIMS) assessment score of 11 indicating moderate cognitive impairment. The MDS also identified that R12

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2 565	Continued From page 17 required extensive assistance with personal hygiene. Review of R12's current resident care sheet identified R12 received a weekly bed bath on Friday mornings and had a splint to the left hand that was to be removed daily for hygiene. Review of R12's bath schedule for 8/19/16, indicated R12 had received a bath. The bath schedule identified staff were to PLEASE REMEMBER TO DO NAIL CARE!! The care plan revised 8/24/16, identified R12 required assistance of one staff with personal hygiene and nail care as needed (PRN). R12 also had an order to remove her palm guard in the A.M. with cares and complete hand hygiene which was indicated on the order review report dated 8/1/16-8/31/16. When interviewed on 8/25/16, at 10:58 a.m. nursing assistant (NA)-A stated R12 got a bed bath on Fridays and staff were supposed to do her nails. She stated at times the nail cares did not get done because she received a bed bath instead of a tub bath. NA-A verified it did not look like R12's nail care had been completed with her bed bath on Friday. NA-B verified R12's nails were long, jagged and dirty. NA-B stated she would clean and trim R12's nails right away. NA-B also stated, "I tell my director that they need to do nails with a bed bath too and they don't always do it." When interviewed on 8/25/16, at 11:00 a.m. the DON confirmed R12's care plan was not followed for nail care. Review of the facility policy for Bed bath, last reviewed 12/7/15, included: PROCEDURE: 14. Care of fingernails and toenails is part of the bath. Be certain nails are	2 565		

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2 565	Continued From page 18 clean. R14 was admitted with diagnoses including dementia, chronic obstructive pulmonary disease (COPD), depression, anxiety, and osteoporosis per the admission record face sheet. The quarterly Minimum Data Set (MDS) assessment dated 7/16/16, indicated R14 required extensive assistance with toilet use, dressing, and personal hygiene, and supervision with one person physical assistance with bed mobility, transfer, and locomotion off the unit. R14's care plan last revised 4/4/16, indicated a risk for falls. Interventions included: "Bed and W/C (wheelchair) alarms in place and checked daily for proper functioning." Review of the nursing assistant assignment sheet identified R14 utilized a bed and chair alarm for safety. When interviewed on 8/24/16, at 3:20 p.m. nursing assistant (NA)-D stated R14 required assistance with transfers and toileting though would not always ask staff for assistance. NA-D stated that when R14 is in bed, she would often refuse cares as she just wanted to rest and not be disturbed. NA-D was unsure if the resident utilized an alarm when up in her w/c. On 8/25/16, at 9:53 a.m. R14 was observed lying in bed crossways and appeared to be sleeping. The resident's head was positioned up against the wall with her legs/feet hanging off the exit side of the bed. R14's w/c was observed positioned next to the bed by the resident's feet with brakes off; no bed or chair alarm was visualized. At 10:05 a.m., NA-A stated R14 had probably transferred herself into bed. NA-A confirmed an	2 565		

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alarm was not in place on the chair nor in the bed and should have been. NA-A stated she wasn't working on the resident's hall today but confirmed she had observed the resident utilizing a TABS clip alarm the day before while up in her w/c. NA-A searched R14's room for an alarm but was unable to locate one; NA-A stated the resident had been known to hide or throw away the alarms in the past. NA-A also attempted to reposition the resident in bed but the resident refused and yelled at NA-A to leave her alone. NA-A positioned R14's w/c next to the bed with the brakes locked then exited the room to alert the assistant director of nursing (ADON) that R14 was in need of a bed alarm. Shortly afterwards the ADON and NA-B entered R14's room with a sensor pad alarm. NA-B attempted to reposition R14 in bed while the ADON placed the sensor pad underneath the resident. The ADON was able to place the sensor alarm underneath the resident though R14 continued to refuse repositioning. NA-B stated the resident had refused morning cares earlier though was unsure who had assisted the resident in getting up for the day; NA-B was unsure if R14 had utilized an alarm earlier. NA-B searched R14's room and was unable to locate an alarm. The ADON confirmed the resident was to utilize an alarm when in her w/c and in bed per the plan of care.

R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.

R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total

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2 565	Continued From page 20	2 565		

dependence with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity non pressure initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.

Review of the Weekly Skin Reviews dated 8/9/16 and 8/23/16 indicated: Skin Intact. The skin reviews did not include evidence of other skin conditions including bruising.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was effective."

Further review of R38's medical record did not include evidence of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L

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2 565	Continued From page 21 shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care). When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note.	2 565		

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	00936	A. BUILDING: _____ B. WING _____	08/26/2016

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2 565	Continued From page 22	2 565		

The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the state. RN-A further stated if bruising was occurring frequently or if a larger bruise or hematoma of unknown origin was identified and not explainable would also be reported to the state. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but then did verify that this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated for possible causes nor reported to the state agency when identified on 8/10/16.

When interviewed on 8/26/16, at 8:46 a.m. the DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, and reported to the physician per the plan of care when first identified on 8/10/16.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could

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2 565	Continued From page 23 educate staff to ensure resident care plans are followed. The DON or designee could then perform audits to ensure compliance to resident care plans. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 565		
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 assess for pain and provide the necessary care and services for 1 of 3 residents (R9) in the sample who fell and sustained a femur fracture which resulted in actual harm, significant pain to R9, due to the facility's failure to assess and provide medical care in a timely manner as required. Also the facility failed to provide non pressure related skin care to 1 of 1 resident (R38) who had bruising of unknown origin and failed to ensure services	2 830	Corrected	9/23/16

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2 830	Continued From page 24 were coordinated with the hospice agency for 1 of 1 residents (R28) receiving hospice care. Findings include: Review of R9's admission record identified diagnosis including dementia and osteoporosis without current pathological fracture. R9 was observed on 8/22/16, at 5:24 p.m. sitting in her room in her wheelchair restless and moaning. An interview was attempted about her restlessness and moaning but R9 was unable to respond appropriately to questions. R9's significant change Minimum Data Set (MDS) assessment dated 5/18/16, identified R9 with a Brief Interview for Mental Status (BIMS) score of 00 indicating R9 had severe cognitive impairment. The Care Area Assessment (CAA) associated with the MDS identified R9 was at risk for falls and fall related injuries and required extensive assistance of 2 staff with transfers. Review of R9's care plan revised 3/25/16, identified a physical functioning ADL (activities of daily living)/deficit with interventions that included transfers with assist of one staff and EZ stand lift (mechanical lift) or use 2 staff PRN (as needed). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified R9 required ADL assistance including transfers with stand lift. The certified nursing assistant (NA) care sheet updated 8/23/16, identified R9 requiring the EZ stand and 1 assist for transfers. During review of the nurses notes the following entries were noted: On 8/21/16, at 9:54 p.m. the note identified a	2 830		

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2 830	Continued From page 25 change of condition situation had occurred. It was documented in the note that R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The note further identified minimal pain to right side and that R9 had reddish colored bruises on her right upper back under her right arm. The note also identified R9 stated she had pain "all over." On 8/22/16, at 8:53 a.m. a note identified that R9 had complained of right thigh pain at 6:00 a.m., and was unable to stand and required staff to use a full lift to transfer R9. On 8/22/16, at 4:31 p.m. a note identified R9 was complaining of pain to her right thigh while transferring in the EZ stand (mechanical lift device). On 8/22/16, at 10:28 p.m. a note identified R9 was having marked weakness when attempting to utilize the EZ stand and was not able to transfer safely. The note further indicated a full lift was used to transfer R9 back to bed at bedtime. R9 was noted to have a 6 centimeter (cm) red scrape below her left rib cage, on the outer aspect of her left chest. An addendum to the note at 11:27 p.m. clarified the scrape was on the right not the left. The note also identified R9 had a large light purple hematoma (bruise) that was raised and staff were able to cup their palm around the entire hematoma, The hematoma was identified as being firm to touch and measured 6 cm by 12 cm. R9's upper trochanter area was warm to touch. R9 was noticed to wince in pain with use of the lift as well as when rolled gently in bed. On 8/23/16, at 8:35 a.m. a note identified R9 was	2 830		

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2 830	Continued From page 26	2 830		

transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement.

R9 was transferred to the hospital at 10:50 a.m. on 8/23/16. A note from the emergency room (ER) dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.)identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area.

During interview on 8/23/16, at 11:01 a.m. nursing assistant (NA)-I stated she did not get R9 up that morning. NA-I stated night shift got R9 up. NA-H stated when she transferred R9 to the wheel chair that day she used a full body lift rather than the EZ stand as R9 was sore on the right side.

During interview on 8/23/16, at 2:25 p.m. NA-J stated R9 utilized an EZ stand lift. NA-J stated the instructions to use the EZ stand lift was indicated on the NA care sheet that the aides carry with them.

During interview on 8/23/16, at 2:32 p.m., NA-D stated she was working the evening shift on 8/22/16. NA-D stated when she went to get R9 up out of her recliner with the EZ lift, R9 was leaning way to the left putting all of her weight on the left side, which was not usual for R9. NA-D

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2 830	Continued From page 27 stated R9 could not stand and was wincing with pain. NA-D stated at that time she notified the nurse immediately. NA-D stated that when she went in to put R9 to bed later that evening she again attempted to use the EZ lift and R9 would not put any weight on her right leg and was very pale and weak. NA-D stated staff then used a full body lift to get R9 into bed. NA-D stated she again told the nurse of R9's condition and the nurse then went to check on R9 and took vital signs (vs). During interview on 8/24/16, at 11:21 a.m. the assistant director of nursing (ADON) stated that when R9 was unable to transfer her typical way, going from an EZ lift to a full body lift, the situation should have been looked into and warranted further investigation. The ADON stated,"This would be considered a change of condition for [R9] and she should have been reassessed." The ADON further stated she was not aware of R9's condition until they were going to send her to the hospital. During interview on 8/24/16, at 3:05 p.m. NA-H stated she was transferring R9 from the commode to the bed on 8/21/16 and utilized a transfer belt. During the transfer R9 got her heel caught on the commode and when NA-H went to turn to get resident onto the bed, R9 fell into her and NA-H slid R9 to the floor. NA-H stated R9 grabbed her right leg and complained of pain. During interview on 8/24/16, at 3:32 p.m. registered nurse (RN)-C stated she was working the day shift on 8/22/16. RN-C stated that at approximately 10:00 a.m. an aide told her R9 was having trouble keeping her feet on the EZ lift. RN-C stated that NA-A had reported to her that R9 was moaning and groaning a lot and	2 830		

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2 830	Continued From page 28 complaining of her leg hurting. During interview on 8/24/16, at 2:55 p.m. RN-A stated she had worked the evening of 8/22/16. RN-A stated she was told in report that R9 was transferring poorly during the day. RN-A stated the aides didn't feel safe transferring R9 with the EZ stand lift. RN-A stated staff asked her to go look at R9 which she did and she took R9's VS which were fine. RN-A further stated R9 was grimacing and appeared to be in a lot of pain when she was assisted into bed. RN-A also stated, at around 10:00 p.m. she notice R9's right leg was "out of sync" and she noted the "huge" hematoma on R9's thigh and the "huge" scrape on her side. RN-A stated R9 had facial grimaces while staff were turning her stating,"She was weaker and having a lot of pain.". RN-A stated she did not check to see if one leg was shorter than the other but documented and reported off to the night shift her findings. During interview on 8/25/16, at 6:27 a.m. NA-K stated she had worked the night of the 8/21/16. NA-K stated it was not reported to the NA's that R9 had an incident on the evening shift. NA-K stated R9's leg was swollen and sore and R9 asked for a pain med during the night. NA-K stated when she went to get R9 up in the morning with the EZ lift, R9 was crying and moaning in pain and could not transfer NA-K stated the nurse went in and gave R9 a pain medication and stated she was going to look at R9's leg in the morning. NA-K stated when she sat R9 up R9 complained of pain and started moaning and could not bear weight on her right leg. NA-K stated,"Her leg hurt really bad and she wouldn't put pressure on it, it was swollen at that time." During interview on 8/25/16, at 6:40 a.m. NA-L	2 830		

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2 830	Continued From page 29	2 830		

stated R9 complained of pain when she was rolled over. NA-L also stated R9's leg was swollen and painful with movement and stated, "Anytime we rolled her she grimaced and complained of pain."

During interview on 8/25/16, at 9:37 a.m. NA-A stated she had worked the day shift 8/22/16. NA-A stated R9 was very restless and tired and would not open her eyes when her name was called which would be unusual for R9. NA-A stated she used the EZ stand as that is what the care plan indicated. NA-A stated R9 had a lot of pain with the transfers which was reported to the nurse. NA-A stated R9 was different than her normal, was not transferring well and kept repeating she had pain.

During interview on 8/25/16, at 11:30 a.m. R9's daughter (FA)-A stated she was at the hospital when her mother was transferred on 8/23/16. FA-A stated her mother was in so much pain it was "excruciating to watch." FA-A stated she had seen the x-ray of her mother's right leg and the surgeon had pointed out that the femur was broken at an angle and it was over-lapping 3 inches. The daughter also stated, "How did they not notice this, Her foot was sideways and 3 inches shorter? I don't know how they could even try to stand her up!"

During interview on 8/25/16, at 11:53 a.m. LPN-B stated she was on duty when R9 was lowered to the floor. LPN-B stated she did not notice bruising, did a little range of motion and didn't think the right leg appeared to be fractured.

During interview on 8/26/16, RN-D stated R9 was having pain the morning of 8/22/16. RN-D stated R9 may have had more pain in the right lower

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2 830	Continued From page 30 extremity and stated,"She will have pain after a fall." RN-D stated NA-K had caught her at the end of the shift and reported R9 had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. NA-D stated she gave R9 Tylenol in the morning before she got up. During interview with the ADON on 8/24/16, at 11: 21 a.m. the ADON verified the physician should have been notified sooner of R9's increased pain and inability to transfer. The ADON verified the documentation identified R9 had been demonstrating pain, had swelling of her leg, and was restless from 8/21/16 to 8/23/16. The facility policy "Notification of Change in Resident Health Status" last reviewed 11/11/15, identified the facility would consult the residents physician, nurse practitioner or physician assistant when there was: (A) An accident which results in injury and had the potential for requiring physician intervention." R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet. R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total dependence with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity non pressure initiated	2 830		

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2 830	Continued From page 31 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy. Review of the Weekly Skin Reviews dated 8/9/16 and 8/23/16 indicated: Skin Intact. The skin reviews did not include evidence of other skin conditions including bruising. Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was effective." Further review of R38's medical record did not include evidence of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note	2 830		

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2 830	Continued From page 32 dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care). Further review of the nursing progress notes dated 8/17/16 and 8/18/16 included charting on R38's left upper arm and left thoracic bruising. The medical record did not include monitoring of the bruising after 8/18/16. Review of electronic treatment administration record (eTAR) dated 8/2016 did not include monitoring of R38's bruising.	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 33 When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but verified that this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift nor investigated for possible causes when identified on 8/10/16. When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue is identified the nurse should investigate the source of the skin issue, notify the physician, complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the next shift. Nursing assistants (NA's) are also to let the charge nurse know as soon as they identify a new skin concern. Bruises are initially measured though nursing wouldn't necessarily measure again, but would monitor and indicate if the bruising was getting better or worse; wounds were measured weekly - bruises not necessarily unless there was a significant change. DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior	2 830		

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2 830	Continued From page 34 to admission to the facility and was identified with many bruises upon admission. DON reviewed R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and state agency when first identified on 8/10/16, and subsequently investigated and monitored by nursing. On 8/26/16, at 9:19 a.m. surveyor and DON observed R38 seated in w/c in room with 2 male visitors. DON attempted to remove R38's left arm from his long sleeve shirt but resident became resistive and thus attempt was stopped. Surveyor and DON were able to visualize a portion of the left arm bruising from below R38's left shoulder to the mid upper arm; dark reddish purple bruising noted that surrounded the posterior portion of the resident's upper arm and continued to extend towards the elbow. DON confirmed the bruising continued to be significant and would reattempts to visualize and measure the bruising at a later time. When interviewed on 8/26/16, at 9:37 a.m. the DON reviewed the nursing temporary problem communication book which identified R38's bruising dated 8/17/16. The form indicated that the shift responsible for documentation indicated "all". DON stated with this communication tool the expectation was that nursing would be monitoring and making a chart note daily related to the status of the bruising until healed. DON confirmed R38's bruising had not been monitored daily per the progress notes nor had been added to the eTAR for continued monitoring.	2 830		

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2 830	Continued From page 35 On 8/26/16, at approximately 1:00 p.m. the DON provided measurements of R38's left arm bruising; left posterior upper arm bruising measured 28 centimeters (cm) long x 16 cm wide. The bruising had increased from the last measurement on 8/17/16. A policy on skin was requested but not provided. R28's Significant Change Minimum Data Set (MDS) assessment dated 5/18/16 indicated she required total staff assistance in activities of daily living and had moderate cognitive impairment. R28's care plan dated 6/2/16, identified that R28 received hospice centered care and staff were to coordinate the care plan with Hospice, keep the family informed of change in condition and to notify hospice of any change in condition or medication changes. The hospice care plan dated 5/18/16 indicated a goal of pain management with weekly and as needed nurse visits and social work visits every 6 weeks and as needed. During an observation on 8/24/16, at 9:07 a.m. R28 was sitting up in her recliner chair eating her breakfast. She was alert, neatly dressed and appeared comfortable. During an interview on 8/24/16, at 9:25 a.m. R28 indicated she had not been on hospice care for long and did not know when they would be coming. During an interview on 8/24/16, at 9:30 a.m. licensed practical nurse (LPN)-A indicated if there was something out of the norm she would talk to	2 830		

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2 830	Continued From page 36 the ADON and she would assess whether to call hospice. LPN-A further indicated hospice visits weekly but that she did not know when they come. During an interview on 8/24/16, at 9:51 a.m. the assistant director of nursing (ADON) verified there was no contact information regarding how and when to contact hospice in R28"s chart or on the bulletin board in the nursing office. She further verified they did not know when hospice was coming. They had asked for a schedule in the past but were not provided one. During a phone interview on 8/24/16, at 12:12 p.m. the triage hospice nurse indicated they would bring out contact information and stated, "They had to have removed it". She further verified that hospice would notify the facility on the day of the visit as there are patient schedule changes within the organization from day to day. The triage nurse indicated they tried to see R28 on Thursdays. During interview on 8/24/16, at 3:44 p.m. the administrator indicated that she would expect the hospice to let them know of the schedule and often the hospice would call the morning of the visit. She stated, "We do not have conversations with hospice unless we see them. They have lost all their staff". During interview on 8/24/16, at 3:51 p.m. the director of nursing (DON) indicated she would expect a visit schedule be provided by the hospice organization. In addition the DON verified there were no contact numbers for hospice posted on the chart or in the nursing office should hospice need to be contacted.	2 830		

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2 830	Continued From page 37 A hospice policy was requested from the facility but was not provided. In addition, based on observation, interview and document review the facility failed to provide services in a manner that promoted safety for 2 of 3 residents (R9 & R14) in the sample who were identified at risk for falls. The failure of the facility to provide services in a safe manner resulted in harm to R9 who sustained a right femur fracture. Review of R9's admission record identified diagnoses including dementia and osteoporosis without current pathological fracture. R9 was observed on 8/22/16, at 5:24 p.m. sitting in her room in her wheelchair restless and moaning. An interview was attempted about her restlessness and moaning but R9 was unable to respond appropriately to questions. R9's significant change Minimum Data Set (MDS) assessment dated 5/18/16, identified R9 with a Brief Interview for Mental Status (BIMS) score of 00 indicating R9 had severe cognitive impairment. The Care Area Assessment (CAA) associated with the MDS identified R9 was at risk for falls and fall related injuries and required extensive assistance of 2 staff with transfers. Review of R9's care plan revised 3/25/16, identified a physical functioning ADL/deficit with interventions that included transfers with assist of one staff and EZ stand lift or use 2 staff PRN (as needed). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified R9 required ADL assistance including transfers with stand lift. The certified nursing assistant (NA) care sheet updated 8/23/16, identified R9 requiring the EZ stand and 1 assist for transfers.	2 830		

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2 830	Continued From page 38 During review of the nurses notes the following entries were noted: On 8/21/16, at 9:54 p.m. the note identified a change of condition situation had occurred. It was documented in the note that R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The note further identified minimal pain to right side and that R9 had reddish colored bruises on her right upper back under her right arm. The note also identified R9 stated she had pain "all over." On 8/22/16, at 8:53 a.m. a note identified that R9 had complained of right thigh pain at 6:00 a.m., and was unable to stand and required staff to use a full lift to transfer R9. On 8/22/16, at 4:31 p.m. a note identified R9 was complaining of pain to her right thigh while transferring in the EZ stand (mechanical lift device). On 8/22/16, at 10:28 p.m. a note identified R9 was having marked weakness when attempting to utilize the EZ stand and was not able to transfer safely. The note further indicated a full lift was used to get R9 back to bed at bedtime. R9 was noted to have a 6 centimeter (cm) red scrape below her left rib cage, on outer aspect of left chest. An addendum to the note on 11:27 p.m. clarified the scrape was on the right not the left. The note also identified R9 had a large light purple hematoma (bruise) that was raised and staff were able to cup their palm around the entire hematoma, The hematoma was identified as being firm to touch and measured 6 cm by 12 cm. R9's upper trochanter area was warm to touch.	2 830		

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2 830	Continued From page 39 R9 was noticed to wince in pain with use of the lift as well as when rolled gently in bed. On 8/23/16, at 8:35 a.m. R9 a note identified R9 was transferred with a full body lift. A note from 8/23/16, at 9:30 a.m. identified R9 was having pain in her right thigh with the area being swollen, having a large hematoma and tender to touch and movement. R9 was transferred to the hospital at 10:50 a.m.,. A note from the emergency room (ER) dated 8/23/16, at 11:07 a.m. identified R9's right leg was shortened and externally rotated. A note from 8/23/16, at 13:06 (1:06 p.m.) from the ER identified that R9's physician had contacted the facility and stated R9 had sustained a spiral fracture of the right femur. An admission note from the hospital dated 8/23/16, at 16:02 (4:02 p.m.) identified R9 had a severe right femur fracture. The note indicated can see femur close to skin and R9 demonstrated non- verbal indicators of pain and had a very swollen right femur/hip area. During interview on 8/23/16, at 2:25 p.m. NA-J stated R9 utilized an EZ stand lift. NA-J stated the instructions to use the EZ stand lift was indicated on the NA care sheet that the aides carry with them. During interview on 8/23/16, at 2:32 p.m., NA-D stated she was working the evening shift on 8/22/16. NA-D stated when she went to get R9 up out of her recliner with the EZ lift, R9 was leaning way to the left putting all of her weight on the left side, which was not usual for R9. NA-D stated R9 could not stand and was wincing with pain. NA-D stated at that time she notified the nurse immediately. NA-D stated that when she	2 830		

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2 830	Continued From page 40	2 830		

went in to put R9 to bed later that evening she again attempted to use the EZ lift and R9 would not put any weight on her right leg and was very pale and weak. NA-D stated staff then used a full body lift to get R9 into bed. NA-D stated she again told the nurse of R9's condition and the nurse then went to check on R9 and took vital signs (vs).

During interview on 8/24/16, at 11:21 a.m. the assistant director of nursing (ADON) stated that when R9 was unable to transfer her typical way, going from an EZ lift to a full body lift, the situation should have been looked into and warranted further investigation. The ADON stated,"This would be considered a change of condition for [R9] and she should have been reassessed." The ADON further stated she was not aware of R9's condition until they were going to send her to the hospital.

During interview on 8/24/16, at 3:05 p.m. NA-H stated she was transferring R9 from the commode to the bed on 8/21/16 and utilized a transfer belt. During the transfer R9 got her heel caught on the commode and when NA-H went to turn to get resident onto the bed, R9 fell into her and NA-H slid R9 to the floor. NA-H stated R9 grabbed her right leg and complained of pain.

During interview on 8/24/16, at 2:55 p.m. RN-A stated she had worked the evening of 8/22/16. RN-A stated she was told in report that R9 was transferring poorly during the day. RN-A stated the aides didn't feel safe transferring R9 with the EZ stand lift. RN-A stated staff asked her to go look at R9 which she did and she took R9's vital signs. which were fine. RN-A further stated R9 was grimacing and appeared to be in a lot of pain when she was assisted into bed. RN-A also

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2 830	Continued From page 41 stated, at around 10:00 p.m. she notice R9's right leg was "out of sync" and she noted the "huge" hematoma on R9's thigh and the "huge" scrape on her side. RN-A stated R9 had facial grimaces while staff were turning her stating,"She was weaker and having a lot of pain.". RN-A stated she did not check to see if one leg was shorter than the other but documented and reported off to the night shift her findings. During interview on 8/25/16, at 6:27 a.m. NA-K stated she had worked the night of the 8/21/16. NA-K stated it was not reported to the NA's that R9 had an incident on the evening shift. NA-K stated R9's leg was swollen and sore and R9 asked for a pain med during the night. NA-K stated when she went to get R9 up in the morning with the EZ lift, R9 was crying and moaning in pain and could not transfer NA-K stated the nurse went in and gave R9 a pain medication and stated she was going to look at R9's leg in the morning. NA-K stated when she sat R9 up R9 complained of pain and started moaning and could not bear weight on her right leg. NA-K stated,"Her leg hurt really bad and she wouldn't put pressure on it, it was swollen at that time." During interview on 8/25/16, at 9:37 a.m. NA-A stated she had worked the day shift 8/22/16. NA-A stated R9 was very restless and tired and would not open her eyes when her name was called which would be unusual for R9. NA-A stated she used the EZ stand as that is what the care plan indicated. NA-A stated R9 had a lot of pain with the transfers which was reported to the nurse. NA-A stated R9 was different than her normal, was not transferring well and kept repeating she had pain. During interview on 8/25/16, at 11:30 a.m. R9's	2 830		

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2 830	Continued From page 42 daughter (FA)-A stated she was at the hospital when her mother was transferred on 8/23/16. FA-A stated her mother was in so much pain it was "excruciating to watch." FA-A stated she had seen the x-ray of her mothers right leg and the surgeon had pointed out that the femur was broken at an angle and it was over-lapping 3 inches. The daughter also stated, "How did they not notice this, Her foot was sideways and 3 inches shorter? I don't know how they could even try to stand her up!" During interview on 8/25/16, at 11:53 a.m. LPN-B stated she was on duty when R9 was lowered to the floor. LPN-B stated she did not notice bruising, did a little range of motion and didn't think the right leg appeared to be fractured. During interview on 8/26/16, RN-D stated R9 was having pain the morning of 8/22/16. RN-D stated R9 may have had more pain in the right lower extremity and stated,"She will have pain after a fall." RN-D stated NA-K had caught her at the end of the shift and reported R9 had pain and difficulty transferring. RN-D further stated that on the night of 8/22/16 to 8/23/16, the NA's reported R9 was having pain in her right leg with repositioning. NA-D stated she gave R9 Tylenol in the morning before she got up. The facility policy "Notification of Change in Resident Health Status" last reviewed 11/11/15, identified the facility would consult the residents physician, nurse practitioner or physician assistant when there was: (A) An accident which results in injury and had the potential for requiring physician intervention." R14 was admitted with diagnoses including	2 830		

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2 830	Continued From page 43 dementia, chronic obstructive pulmonary disease (COPD), depression, anxiety, and osteoporosis per the admission record face sheet. The quarterly Minimum Data Set (MDS) assessment dated 7/16/16, indicated R14 required extensive assistance with toilet use, dressing, and personal hygiene, and supervision with one person physical assistance with bed mobility, transfer, and locomotion off the unit. R14's care plan last revised 4/4/16, indicated a risk for falls. Interventions included: "Bed and W/C (wheelchair) alarms in place and checked daily for proper functioning." Review of the nursing assistant assignment sheet identified R14 utilized a bed and chair alarm for safety. When interviewed on 8/24/16, at 3:20 p.m. nursing assistant (NA)-D stated R14 required assistance with transfers and toileting though would not always ask staff for assistance. NA-D stated that when R14 is in bed, she would often refuse cares as she just wanted to rest and not be disturbed. NA-D was unsure if the resident utilized an alarm when up in her w/c. On 8/25/16, at 9:53 a.m. R14 was observed lying in bed crossways and appeared to be sleeping. The resident's head was positioned up against the wall with her legs/feet hanging off the exit side of the bed. R14's w/c was observed positioned next to the bed by the resident's feet with brakes off; no bed or chair alarm was visualized. At 10:05 a.m., NA-A stated R14 had probably transferred herself into bed. NA-A confirmed an alarm was not in place on the chair nor in the bed and should have been. NA-A stated she wasn't working on the resident's hall today but confirmed she had observed the resident utilizing a TABS	2 830		

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2 830	Continued From page 44 clip alarm the day before while up in her w/c. NA-A searched R14's room for an alarm but was unable to locate one; NA-A stated the resident had been known to hide or throw away the alarms in the past. NA-A also attempted to reposition the resident in bed but the resident refused and yelled at NA-A to leave her alone. NA-A positioned R14's w/c next to the bed with the brakes locked then exited the room to alert the assistant director of nursing (ADON) that R14 was in need of a bed alarm. Shortly afterwards the ADON and NA-B entered R14's room with a sensor pad alarm. NA-B attempted to reposition R14 in bed while the ADON placed the sensor pad underneath the resident. The ADON was able to place the sensor alarm underneath the resident though R14 continued to refuse repositioning. NA-B stated the resident had refused morning cares earlier though was unsure who had assisted the resident in getting up for the day; NA-B was unsure if R14 had utilized an alarm earlier. NA-B searched R14's room and was unable to locate an alarm. The ADON confirmed the resident was to utilize an alarm when in her w/c and in bed per the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff to ensure resident care plans are followed and that new conditions are assessed, monitored, and treated as needed. The DON or designee could then perform audits to ensure resident's receive care in accordance with their individualized care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		

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2 860	Continued From page 45	2 860		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide nail care for 1 of 3 residents (R12) reviewed for activities of daily living (ADL's). Findings include: During observation of cares on 8/22/16, at 4:58 p.m. R12 was observed in her room with long, jagged fingernails with dark brown substance underneath on both hands. R12 confirmed her nails were long and soiled and stated she needed to have her nails cut as they were too long. On 8/24/16, at 10:25 a.m. R12 was observed lying in bed. During the observation R12 was noted to continue to have long, jagged fingernails that were soiled underneath. R12 was further noted have a black/brown substance on her left thumb cuticle. R12 was interviewed during the observation and stated she needed to have her nails cut and that staff were going to do it sometime later in the day. On 8/24/16, at 4:00 p.m. R12's nails remained long, jagged and dirty with the black/brown substance remaining on the left thumb. R12	2 860	Corrected	9/23/16

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GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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2 860	Continued From page 46 stated, staff had not come to her room to cut her nails and she wasn't sure when they would. On 8/25/16, at 7:31 a.m. R12 was observed in her room with nails remaining long, jagged and dirty with the black/.brown substance still present on the left thumb cuticle. R12 also stated her nails were too long and she needed them cut. R12's quarterly minimum data set (MDS) assessment dated 8/10/16, included a Brief Interview for Mental Status (BIMS) assessment score of 11 indicating moderate cognitive impairment. The MDS also identified that R12 required extensive assistance with personal hygiene. Review of R12's current resident care sheet identified R12 received a weekly bed bath on Friday mornings and had a splint to the left hand that was to be removed daily for hygiene. Review of R9's bath schedule for 8/19/16, indicated R12 had received a bath. The bath schedule identified staff were to PLEASE REMEMBER TO DO NAIL CARE!! The care plan revised 8/24/16, identified R12 required assistance of one staff with personal hygiene and nail care as needed (PRN). R12 also had an order to remove her palm guard in the A.M. with cares and complete hand hygiene which was indicated on the order review report dated 8/1/16-8/31/16. When interviewed on 8/25/16, at 10:58 a.m. nursing assistant (NA)-A stated R12 got a bed bath on Fridays and staff were supposed to do her nails. She stated at times the nail cares did not get done because she received a bed bath instead of a tub bath. NA-A verified it did not look like R12's nail care had been completed with her bed bath on Friday. NA-B verified R12's nails	2 860		

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2 860	Continued From page 47 were long, jagged and dirty. NA-B stated she would clean and trim R12's nails right away. NA-B also stated, "I tell my director that they need to do nails with a bed bath too and they don't always do it." When interviewed on 8/25/16, at 11:00 a.m. the director of nursing (DON) confirmed R12 should have had nail care provided per her plan of care. The DON further confirmed the NA's were responsible for nail care when resident's received their bath regardless if a bed bath, shower or tub bath is given. Review of the facility policy for Bed bath, last reviewed 12/7/15, included: PROCEDURE: 14. Care of fingernails and toenails is part of the bath. Be certain nails are clean. SUGGESTED METHOD FOR CORRECTION: The DON should ensure that staff are re-educated as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The DON should conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 860		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		9/23/16

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21426	Continued From page 48 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the baseline tuberculosis (TB) screening process for newly hired employees was completed according to the Centers for Disease Control and Prevention (CDC) guidelines for 3 of 5 employees (nursing assistant (NA)-E, NA-F & NA-G) who did not have a symptom screen and 2 step tuberculin skin test (TST) completed. Findings include: NA-E, hire date of 6/15/16, did not have a symptom screen and 2-step TST completed upon hire. NA-F, hire date of 7/28/16, did not have a symptom screen and 2-step TST completed upon hire.	21426	Corrected	

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21426	Continued From page 49 NA-G, hire date of 5/19/16, did not have a symptom screen and 2-step TST completed upon hire. During an interview on 8/26/16, at 12:50 p.m. the director of nursing (DON) confirmed the symptom screen and 2 step TSTs had not been completed for 3 of 5 new employees. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the two step Mantoux process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were appropriately secured at all times during observations of medication pass for 1 of 2 residents (R60).	21610	Corrected	9/23/16

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21610	Continued From page 50 Findings include: R60 had physician orders dated 8/12/16, for insulin aspart, five units to be injected before meals and insulin aspart on a sliding scale. The orders indicated that when R60's blood sugar was between 150 milligrams per deciliter (mg/dL) and 200 mg/dL, two additional units of aspart were to be administered. During observations on 8/24/16, at 5:05 p.m., the 100 wing medication cart was positioned outside of room 106. Observations at that time revealed registered nurse (RN)-A removed R60's Novolog (same as aspart) insulin pen from the medication cart drawer, wasted two units of insulin, dialed the pen to five units and placed the insulin pen on top of the medication cart. RN-A stated the routine was to set up the insulin and leave it on top of the medication cart while RN-A checked R60's blood sugar. Observation at that time revealed RN-A walked away from the medication cart to room 112 located near the end of the 100 wing hallway. RN-A then checked R60's blood sugar in room 112. When the blood sugar check was completed, RN-A returned to the medication cart, still positioned outside of room 106. Observations at that time revealed two residents and two visitors were standing at room 109 near the medication cart. RN-A removed the insulin pen, dialed two more units to equal seven units, and returned to administer the insulin to R60. During interview on 8/24/16, at 6:00 p.m., the director of nursing verified she expected medications to be locked in the medication cart and not left unattended on top of the medication cart. Document review of facility's Medication	21610		

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21610	Continued From page 51 Administration-Preparation and General Guidelines policy dated 6/2015, page 4 #16 indicated that, "During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure medications are appropriately stored and locked. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21610		
21915	MN St. Statute 144.651 Subd. 27 Patients & Residents of HC Fac.Bill of Rights Subd. 27. Advisory councils. Residents and their families shall have the right to organize, maintain, and participate in resident advisory and family councils. Each facility shall provide assistance and space for meetings. Council meetings shall be afforded privacy, with staff or visitors attending only upon the council's invitation. A staff person shall be designated the responsibility of providing this assistance and responding to written requests which result from council meetings. Resident and family councils	21915		9/23/16

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21915	Continued From page 52 shall be encouraged to make recommendations regarding facility policies. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to organize a family council on at least an annual basis. This had the potential to affect all 37 resident families who reside in the facility. Findings include: During interview on 8/23/16, at 10:06 a.m. the administrator confirmed the facility did not have an existing family council. The administrator further confirmed she had not formally attempted to organize a family council in the past year. SUGGESTED METHOD OF CORRECTION: The administrator or designee should ensure thorough attempts are made to develop a family council. The administrator or designee should develop monitoring systems to ensure thorough attempts are made to initiate the family council. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21915	Corrected	
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	21980		9/23/16

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individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of

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21980	Continued From page 54 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report an occurrence of possible abuse/neglect immediately to the designated State agency for 1 of 3 residents (R9) who sustained a spiral fracture of the right femur as a direct result of the care plan not being followed, and for 1 of 1 resident (R38) with significant bruising of unknown origin. Findings include: Review of R9's admission record identified diagnoses including dementia and osteoporosis without current pathological fracture. R9's Minimum Data Set (MDS) significant change assessment dated 5/18/16, identified a Brief Interview for Mental Status score of 00 indicating severe cognitive impairment. The Care Area Assessment (CAA) identified R9 at risk for falls and fall related injuries and the need for extensive assistance of 2 staff with transfers. Review of R9's care plan revised 3/25/16, identified R9 had physical functioning ADL(activities of daily living) deficit with interventions that included R9 should have transfer assist of one staff and EZ stand lift or use 2 staff as needed (PRN). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified ADL's included transfers with the use of stand lift. The certified nursing assistant (NA) care sheet, updated 8/23/16, identified R9 required the EZ stand and 1 staff assist for transfers.	21980	Corrected	

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21980	Continued From page 55 Review of R9's nursing notes dated 8/21/16, at 9:54 p.m. identified R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed. The incident report dated 8/21/16, under the IDT (interdisciplinary team) review and recommendations, identified care plan of 1 assist w/ (with) EZ stand for transfers not followed at time of fall. Education provided to nursing assistant (NA) assisting R9. R9 will remain an EZ stand for transfers. Further review of the nurses' notes identified R9 was transferred to the hospital 8/23/16 with a spiral fracture of the right femur. During interview on 8/24/16, at 3:05 p.m. NA-H stated she transferred R9 on 8/21/16 when R9 was lowered to the floor. NA-H stated while she was transferring R9 between the commode and bed R9's right heel caught on the commode as she was turning her, and R9 "Fell into me and I slid her to the floor." NA-H stated staff were supposed to use the EZ stand lift to transfer R9. NA-H stated she used the transfer belt at times to transfer R9 between the commode or wheelchair and the bed. NA-H also stated she was aware the EZ stand was supposed to be used for R9 when transferring. NA-H stated "I screwed up big by not using it." When asked if there was any special reason she used the transfer belt and not the stand NA-H stated both lifts were in use and they were short staffed. During interview with the director of nursing (DON) on 8/23/16, at 3:12 p.m. the DON verified NA-H had not followed R9's care plan for transfers and that no report had been filed with the State agency until today (8/23/16). During interview on 8/25/16, at 11:53 a.m.	21980		

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21980	Continued From page 56 licensed practical nurse (LPN)-B verified NA- H did not follow the care plan. LPN-B said NA-H had stated she'd thought she could just transfer R9 with the belt since R9 was right by the bed. NA-H then stated R9's foot had gotten caught on the commode when she was turning her and R9 had fallen towards NA-H. R9's medical record documents lacked evidence an incident report had been submitted to the State agency until 8/23/16, 2 days after the incident occurred, and after R9 had been sent to the hospital and diagnosed with a spiral fracture. The incident report submitted on 8/23/16 indicated the report of maltreatment being reported was neglect. R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet. R38's 14-day admission minimum data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total assistance with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity, non pressure, initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.	21980		

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21980	Continued From page 57 Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following, "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note documented by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included, "Did request prn (as needed) Oxycodone at hs (hour of sleep) for left upper arm pain, that was effective." Further review of R38's medical record revealed there was no mention of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy here at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have	21980		

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increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care).

Review of the Verification of Investigation report dated 8/18/16, completed by the executive director (ED) included the following:
"Description of event/allegation: Bruising has occurred from an unknown cause. NH (nursing home) staff conclude bruising to left arm and left outer torso likely occurred from mechanical lift use for transfers. A progress note 8/10 by nursing indicates bruising first noted then. An SBAR was completed 8/17 with family and MD notification completed at that time.
Assessment of Resident: on 8/10 it was first noted resident presented with new bruising to left upper arm from shoulder down to elbow, cause was unknown. SBAR report was completed by NOC (night) nurse 8/17 in relation to left arm bruising as well as extended bruising to left outer torso region. Bruises are dark purple. Left arm is more swollen than the right. No hematoma or open skin found on assessment. Last fall in facility was 7/29/16.
Resident interview summary: Resident denies

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	00936	A. BUILDING: _____ B. WING _____	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

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21980	Continued From page 59	21980		

pan to bruised areas. Resident is unable to recall cause of bruising and was unaware of bruising until notified by staff.
Casual/contributing factors and observations: Resident had a fall on 7/29 from bed to floor. He is chronically on ASA 325 mg as only anticoagulation for MI prevention. Resident is dependent with all transfers which requires mechanical lift use and 1-2 person assist. Resident noted to have increased mental confusion since admission which is being monitored and documented by nursing. Resident has very fragile skin.
Recommendation/interventions taken to prevent reoccurrence: More careful handling reinforced to CNAs during ADLs and mechanical lift transfers r/t (related to) fragile skin and anticoagulation medicine.
Summary and outcome of investigative findings: Nursing, resident and family unable to determine exact time, location or occurrence in which bruising took place. There were no witnesses to an event. Only known event was from documented fall from self transfer on 7/29. Resident was evaluated and a skin examination took place on 8/17 by Dr [physician name]. No medication changes or further f/u (follow up) ordered by MD. "

When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the State. RN-A further stated if bruising was occurring frequently

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21980	Continued From page 60	21980		

or if a larger bruise or hematoma of unknown origin was identified and not explainable would also be reported to the state. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but verified that this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated for possible causes, nor reported to the State agency when identified on 8/10/16.

When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue is identified the nurse should investigate the source of the skin issue, notify the physician, complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the next shift. Nursing assistants (NA's) are also to let the charge nurse know as soon as they identify a new skin concern. Bruises are initially measured though nursing wouldn't necessarily measure again, but would monitor and indicate if the bruising was getting better or worse; wounds were measured weekly - bruises not necessarily unless there was a significant change. DON further stated if a large or suspicious bruise of unknown origin was not explainable she would expect it to be reported immediately to the state. DON stated she was unaware of R38's left arm bruising first identified on 8/10/16 and subsequently on 8/17/16. DON stated R38 was prone to bruising as had fallen many times prior to admission to the facility and was identified with many bruises upon admission. DON reviewed

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21980	Continued From page 61 R38's medical record and confirmed the resident was not admitted with the left arm bruising. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and state agency when first identified on 8/10/16, and subsequently investigated and monitored by nursing. When interviewed on 8/26/16, at 9:04 a.m. the ED stated after investigating R38's left upper arm and left thoracic bruising deemed that it was probably from the full body lift used for this resident. The ED confirmed the facility did not report the significant bruising of unknown origin to the State agency prior too or after investigating the possible source of the bruising. Further, the ED was unaware if staff had been observed using the lift on R38 or training provided following the investigation into the bruising. SUGGESTED METHOD OF CORRECTION: The administrator or designee could provide education and training regarding responsibilities of staff, to ensure injuries of unknown origin and allegations of abuse are thoroughly investigated and reported to the State agency and administrator immediately. All incidents could be audited and the results reported to the quality assurance committee for further review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each	22000		9/23/16

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facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

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

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22000	Continued From page 63 authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement their policy related to the immediate reporting of abuse/neglect to the administrator and the designated State agency for 1 of 3 residents (R9) who sustained a spiral fracture of the right femur as a direct result of the care plan not being followed, and 1 of 1 resident (R39) with significant bruising of unknown origin. In addition, the policy did not clearly define what would constitute mistreatment, abuse, neglect, injuries of unknown source or misappropriation of resident's property. Findings include: The policy titled, Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property dated 7/12/16, included the following: It is the policy of the Company to take appropriate steps to prevent the occurrence of abuse, neglect, injuries of unknown origin and misappropriation of resident property and to ensure that all alleged violations of Federal or State laws which involve mistreatment, neglect, abuse, injuries of unknown origin and misappropriation of resident property ("alleged violations"), are reported immediately to the	22000	Corrected	

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22000	Continued From page 64 Executive Director (hereinafter "ED") of the center AND the Director of Rehabilitation (DOR) if it is Aegis employee. Such violations will also be reported to State agencies in accordance with existing State law. The ED will direct a thorough investigation of each such alleged violation unless there is a conflict of interest or the ED is implicated in the alleged violation, The ED is responsible to report the results of all investigations to the state agencies as required by state and federal law. The policy further included under identification: Reporting of suspected alleged violations is required of every employee. In addition, under the section titled Reporting, the policy included: Any employee who suspects an alleged violation shall immediately notify the ED AND DOR if it is an Aegis employee. The ED AND DOR shall also notify the appropriate state agency, in accordance with state law, as well as notify immediate management. The results of all investigations must be reported by the ED to the appropriate State agency, as required by State law, within five (5) working days of the alleged violation. The policy did not clearly define what would constitute mistreatment, abuse, neglect, injuries of unknown source or misappropriation of resident's property. Review of R9's admission record identified diagnoses including dementia and osteoporosis without current pathological fracture. R9's Minimum Data Set (MDS) significant change assessment dated 5/18/16, identified a Brief Interview for Mental Status score of 00 indicating	22000		

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22000	Continued From page 65 severe cognitive impairment. The Care Area Assessment (CAA) identified R9 at risk for falls and fall related injuries and the need for extensive assistance of 2 staff with transfers. Review of R9's care plan revised 3/25/16, identified R9 had physical functioning ADL(activities of daily living) deficit with interventions that included R9 should have transfer assist of one staff and EZ stand lift or use 2 staff as needed (PRN). Review of the quarterly interdisciplinary resident review dated 8/15/16, identified ADL's included transfers with the use of stand lift. The certified nursing assistant (NA) care sheet, updated 8/23/16, identified R9 required the EZ stand and 1 staff assist for transfers. Review of R9's nursing notes dated 8/21/16, at 9:54 p.m. identified R9 was being transferred from the commode to the bed with a transfer belt and slid down on the floor next to her bed, The incident report dated 8/21/16, under the IDT (interdisciplinary team) review and recommendations, identified care plan of 1 assist w/ (with) EZ stand for transfers not followed at time of fall. Education provided to NA assisting R9. R9 will remain an EZ stand for transfers. Further review of the nurses notes identified R9 transferred to hospital 8/23/16 with a spiral fracture of the right femur. During interview on 8/24/16, at 3:05 p.m. nursing assistant (NA)-H stated she transferred R9 on 8/21/16 when R9 was lowered to the floor. NA-H stated while she was transferring R9 between the commode and bed R9's right heel caught on the commode as she was turning her and R9, "Fell into me and I slid her to the floor." NA-H stated staff were supposed to use the EZ stand	22000		

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22000	Continued From page 66 lift to transfer R9. NA-H stated she used the transfer belt at times to transfer R59 between the commode or wheelchair and the bed. NA-H also stated she was aware the EZ stand was supposed to be used for R9 when transferring. NA-H stated "I screwed up big by not using it." When asked if there was any special reason she used the transfer belt and not the stand NA-H she stated both lifts were in use and they were short staffed. During interview with the director of nursing (DON) on 8/23/16, at 3:12 p.m. the DON verified NA-H did not follow R9's care plan for transfers and that no report had been filed with the state agency until 8/23/16. During interview on 8/25/16, at 11:53 a.m. licensed practical nurse (LPN)-B verified NA- H did not follow the care plan. NA-H stated she thought she could just transfer R9 with the belt since R9 was right by the bed. NA-H then stated R9's foot got caught on the commode when she was turning her and R9 fell in a direction towards NA-H. R9's medical record documents lacked evidence an incident report was submitted to the State agency until 8/23/16, 2 days after the incident occurred, and R9 was sent to the hospital and diagnosed with a spiral fracture. The incident report submitted on 8/23/16 indicated the report of maltreatment reported was neglect. R38 was admitted to the facility on 7/19/16 with diagnoses including unspecified fall, acute kidney failure, atrial fibrillation, chronic peripheral venous insufficiency, and macular degeneration per the admission record face sheet.	22000		

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R38's 14-day admission data set (MDS) included a brief interview for mental status (BIMS) score of 12 indicating moderate cognitive impairment. The MDS further indicated R38 required total assistance with transfers and bathing, and extensive assistance with bed mobility, locomotion on/off unit, dressing, toilet use, and personal hygiene. The care plan included a focus of altered skin integrity non pressure initiated 8/1/16. Interventions included: Conduct weekly skin inspection. Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor, notify physician of significant findings. Skin assessment to be completed per Living Center Policy.

Review of the nursing progress note by registered nurse (RN)-A dated 8/10/16, at 23:25 (11:25 p.m.) included the following: "Noted bruising on left arm from shoulder to elbow. Area soft and resident denies pain to touch. Continues to need full lift for transfers and remains incontinent of both bladder and stool." The note did not include measurements of the left arm bruising nor evidence of notification to the physician or other nursing staff. A subsequent nursing progress note by RN-A dated 8/14/16 at 23:13 (11:13 p.m.) included: "Did request prn Oxycodone at HS (hour of sleep) for left upper arm pain, that was effective."

Further review of R38's medical record did not include evidence of the bruising until a nursing progress note dated 8/17/16 at 02:42 (2:42 a.m.). The progress note indicated: Type: SBAR - Change of Condition Situation: 0100 (1:00 a.m.) CNAs (certified nursing assistants) discovered lg. (large) dk. (dark) purple bruised area on posterior aspect of L (left) upper arm extending from L shoulder to L elbow and a smaller bruised area

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22000	Continued From page 68 on lateral L thoracic area of res.'s (resident's) body that appear to be new and were not present on admission assessment paper form 7/19/16. There is a brief notation in a Gen. (general) Note dated 8/10/16 @ (at) 2325 re: a L upper arm bruise from shoulder to elbow, no measurement. Background: Last fall here at this facility is on 7/29/16. Res. is on ASA (aspirin) 325 mg p.o. (by mouth) daily for MI (myocardial infarction) prevention, has not be on p.o. or injectable anticoagulation therapy her at GLC (Golden Living Center) since admission. Most recent admission here has [sic] for post hip fx (fracture) rehab. (rehabilitation). Medical hx (history) list does not include platelet or blood clotting factors pathology. Noted to have increased mental confusion on 8/16/16. Elderly male 96 y.o. (years old). Assessment: measurements - posterior L upper arm, 28 cm (centimeters) L (long) x (by) 12 cm W (wide) is dk. purple and soft. Lateral L thoracic 8 cm L x 10 cm W is a lighter purple, soft. No palpable firm areas on either location. This writer is unable to find a lab report in paper chart re: a CBC (complete blood count) or platelet count result. Response: This writer initiated a Temporary Problem for communication to lic (licensed) nursing staff for on-going assessment and charting. This writer will fax a note re: this issue to Dr. [physician name] at local clinic. This writer is not certain that bruising is new occurrence due to the notation in the 8/10/16 General Note/Progress Notes in PCC (point click care). Review of the Verification of Investigation report dated 8/18/16, completed by the executive director (ED) included the following: Description of event/allegation: Bruising has occurred from an unknown cause. NH (nursing home) staff conclude bruising to left arm and left	22000		

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22000	Continued From page 69 outer torso likely occurred from mechanical lift use for transfers. A progress note 8/10 by nursing indicates bruising first noted then. An SBAR was completed 8/17 with family and MD notification completed at that time. Assessment of Resident: on 8/10 it was first noted resident presented with new bruising to left upper arm from shoulder down to elbow, cause was unknown. SBAR report was completed by NOC (night) nurse 8/17 in relation to left arm bruising as well as extended bruising to left outer torso region. Bruises are dark purple. Left arm is more swollen than the right. No hematoma or open skin found on assessment. Last fall in facility was 7/29/16. Resident interview summary: Resident denies pan to bruised areas. Resident is unable to recall cause of bruising and was unaware of bruising until notified by staff. Casual/contributing factors and observations: Resident had a fall on 7/29 from bed to floor. He is chronically on ASA 325 mg as only anticoagulation for MI prevention. Resident is dependent with all transfers which requires mechanical lift use and 1-2 person assist. Resident noted to have increased mental confusion since admission which is being monitored and documented by nursing. Resident has very fragile skin. Recommendation/interventions taken to prevent reoccurrence: More careful handling reinforced to CNAs during ADLs and mechanical lift transfers r/t (related to) fragile skin and anticoagulation medicine. Summary and outcome of investigative findings: Nursing, resident and family unable to determine exact time, location or occurrence in which bruising took place. There were no witnesses to an event. Only known event was from documented fall from self transfer on 7/29.	22000		

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22000	Continued From page 70 Resident was evaluated and a skin examination took place on 8/17 by Dr [physician name]. No medication changes or further f/u (follow up) ordered by MD. When interviewed on 8/24/16, at 4:16 p.m. RN-A stated when a new skin condition for a resident is identified the charge nurse would assess the resident and initiate an SBAR (situation, background, assessment, recommendation) note. The nurse would then notify the physician, create a temporary care plan, and pass on the resident's change in condition in report to the next shift. RN-A stated a bruise of unknown origin, if suspicious, would be reported to the State. RN-A further stated if bruising was occurring frequently or if a larger bruise or hematoma of unknown origin was identified and not explainable would also be reported to the State. Surveyor reviewed the 8/10/16 progress note written by RN-A pertaining to R38's left arm bruising. RN-A confirmed the resident had large bruising to the left upper arm that extended from the shoulder to the elbow. RN-A stated the resident had a history of bruising but verified that this amount of bruising was unusual for the resident. RN-A stated she should have completed an SBAR note and notified the physician and confirmed that had not been done. RN-A further verified the bruising had not been passed on to the next shift, investigated for possible causes nor reported to the State agency when identified on 8/10/16. When interviewed on 8/26/16, at 8:46 a.m. the director of nursing (DON) stated when a new skin issue is identified the nurse should investigate the source of the skin issue, notify the physician, complete an SBAR note, and add the skin issue to the temporary problem list to pass on to the next shift. Nursing assistants (NA's) are also to	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00936	A. BUILDING: _____ B. WING _____	08/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - LA CRESCENT	101 SOUTH HILL STREET LA CRESCENT, MN 55947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 71 let the charge nurse know as soon as they identify a new skin concern. DON further stated if a large or suspicious bruise of unknown origin was not explainable she would expect it to be reported immediately to the state. DON confirmed the large area of bruising of unknown origin to R38's left arm should have been assessed with completion of an SBAR note, reported to the physician, administrator, and State agency when first identified on 8/10/16. When interviewed on 8/26/16, at 9:04 a.m. the ED stated after investigating R38's left upper arm and left thoracic bruising deemed that it was probably from the full body lift used for this resident. ED confirmed the facility did not report the significant bruising of unknown origin to the State agency prior too or after investigating the possible source of the bruising. Further, the ED was unaware if staff had been observed using the lift on R38 or training provided following the investigation into the bruising. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could review the policy and procedure for abuse/neglect and provide education to all employees. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		