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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CG71

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245280**

2. STATE VENDOR OR MEDICAID NO. (L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/25/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 04/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/09/2016 (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 **06/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245280

April 26, 2016

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

Dear Ms. Barnes:

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 April 1, 2016 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 26, 2016

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: Project Number S5280025

Dear Ms. Barnes:

On March 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 3, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 3, 2016, effective April 1, 2016 and therefore remedies outlined in our letter to you dated March 22, 2016, will not be imposed.

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

Sincerely,

Kamala Fiske-Downing

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

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
245280 Y1	A. Building B. Wing Y2	4/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

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 F0241	Correction	ID Prefix F0278	Correction	ID Prefix F0279	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	04/01/2016	LSC	04/01/2016	LSC	04/01/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0315	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(d)	Completed
LSC	04/01/2016	LSC	04/01/2016	LSC	04/01/2016
ID Prefix F0325	Correction	ID Prefix F0329	Correction	ID Prefix F0371	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.35(i)	Completed
LSC	04/01/2016	LSC	04/01/2016	LSC	04/01/2016
ID Prefix F0428	Correction	ID Prefix F0431	Correction	ID Prefix F0520	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.75(o)(1)	Completed
LSC	04/01/2016	LSC	04/01/2016	LSC	04/01/2016
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	04/26/2016	10160	4/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/3/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245280	A. Building 01 - MAIN BUILDING 01 B. Wing	4/22/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 04/01/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 04/01/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 04/26/2016	SIGNATURE OF SURVEYOR 37008	DATE 4/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/2/2016	☐ 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: CG71

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245280**

2. STATE VENDOR OR MEDICAID NO. (L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 03/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/01/2016 (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 :
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22. ORIGINAL DATE OF PARTICIPATION **06/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 22, 2016

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: Project Number S5280025

Dear Ms. Barnes:

On March 3, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

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 April 12, 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 April 12, 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 3, 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 September 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote a dignified dining experience for 5 of 5 residents (R18, R22, R23, R58 and R73) who were observed during meals. Findings Include: R18, R22 and R23 were observed during a dining experience located in the second floor dining room on 3/1/2016 starting at 11:52 a.m. All of the residents were served their food in the dining room by 12:23 p.m. At 12:38 p.m. R18 motioned surveyor over to her table asked for her milk. R18	F 241	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law. It is the policy of this facility to provide a dignified dining experience for all residents of the facility. Some of the ways this has been achieved for residents:	4/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2016

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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	245280	A. BUILDING _____ B. WING _____	03/03/2016

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F 241	Continued From page 1 wanted surveyor to hand her the cup of milk so she could take a drink. Surveyor asked staff member to assist R18 with her milk. The staff member assisted R18 with her milk and proceeded to stand by R18 and attempted to give her a bite of her food. The staff member then stated to R18, "I will sit down and help you today. I think that will be the easiest." The staff member sat down by R18 and started to assist her to eat her meal. R23 who sat at the same dining room table as R18 has had her food placed in front of her since 12:23 p.m. and staff have not encourage R23 to eat or offered to assist her with her meal. R22 was observed to be sitting at the table next to R18 and R23 and was observed to be not eating her lunch. Staff have not approached R22 to encourage her or offer assistance to eat her meal. At 12:35 p.m. staff have not encouraged or offered to assistance with their meals to R23 or R22. At 12:46 p.m. R23 and R22 have not been encouraged to eat or offered assistance to eat their meals. At 12:48 p.m. nursing assistant (NA)-B approached R23 and offered to assist her with her meal. NA-B sat down beside R23 and started assist her to eat. NA-B did not check the temperature of the food to see if it was still warm. The food had been placed in front of R23 by 12:23 p.m. and she was first offered assistance to eat her meal at 12:48 p.m. R22 has not eaten any of her food, has not been encouraged to eat or offered assistance to eat at 12:52 p.m. At 1:02 p.m. nursing assistance (NA)-A approached R22 to record her meal intake. NA-A stated, "Are you done? You did not eat anything. Are you not hungry? You should try to eat. Your coffee is sitting here for you." NA-A stated to another staff member, "I am trying to get this one [R22] to eat or drink something." During an interview on 3/01/2016, at 1:08 p.m.	F 241	18,22,23,58 &73 is by Care Coordinator updating each residents care plan to focus on the need for additional help with their dining experience. Social Worker, DON, MDS, Nurse and Care Coordinator to weekly audit the dining rooms. In this case, after the surveyor reported the dining experience for the above mentioned residents, the nursing staff was immediately educated, at time of survey, to make sure each resident is assisted with their meal in a timely manner. Residents were also arranged in the dining room to facilitate assistance by staff. To enhance currently compliant operations and under the direction of the Director of Nurses all staff will receive in-service training regarding state and federal requirements for minimizing undignified dining experience incidents. The training will emphasize the importance of dignified dining experiences as based on the resident□s care plan, and residents rights. Effective 3/4/16 the quality-assurance team will track implementation under supervision of the Director of Nursing and/or Dietary Manager to monitor resident□s dignified dining experience. The Director of Nurses and/or Dietary Manager or designated quality-assurance representative will perform the following systematic changes: Charge nurse will be present on 2nd and 3rd dining area to supervise; weekly checking and documenting resident□s dining experience. This audit will be completed until it goes through the QA&A board for review and acceptance. Audits will be	

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F 241	Continued From page 2 NA-A stated R22, ate independently but we have been needing to help her and stated sometimes we actually have to feed her. NA-A confirmed R22 was not encouraged or offered assistance to eat her meal until NA-A approached R22 to record her meal intake for the meal. NA-A stated R18 was independent with eating and stated she would not eat if she does not like the food. NA-A stated R23 was independent with eating finger foods and stated we have been needing to sit by her and help her eat lately. NA-A confirmed R23 was not served finger foods for lunch today. NA-A stated they had five residents that required assistance with eating in the dining room for lunch today and there were three staff members to assist residents. NA-A confirmed R18 and R23 were served their meals and had to wait for staff to be available to help they eat. R22, R23, and R18 were observed during a dining experience located in the second floor dining room on 3/3/16 starting at 12:09 p.m. R22 had been served her food, was sitting at the table with her eyes closed and was not eating her meal. At 12:11 p.m. R23 was brought into the dining room. At 12:13 p.m. a staff member stated to R23, "I have a sandwich and coffee for you" then walked away. At 12:14 p.m. a staff asked R23 if she was going to eat, offered her help, moved a chair to sit by R23 and started to assist her to eat. At 12:16 p.m., R22 was observed to not be eating her meal and has not been encouraged to eat her meal or offered assistance to eat her meal. At 12:18 p.m. the staff member assisting R23 to eat her lunch left R23 to assist R74 with her positioning needs in her broad chair and then started to assist R74 with eating her meal leaving R23 without assistance. R23 did not attempt to eat her lunch on her own after the staff	F 241	done to assure compliance , and the findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	

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member left her to assist R74. At 12:22 p.m. R22 has not had any staff assistance to encourage her to eat or offer assistance to eat her meal since the staff member that was assisting her started to help R74. At 12:23 p.m. a staff member entered the dining room, sat down by R22 started to assist her to eat her meal. At 12:36 a staff member returned to R23 who had not been assisted since 12:18 pm. when the staff left her to help R74 to eat.

R18's care plan included, "The resident has nutritional problem or potential nutritional problem r/t [related to] vascular dementia. She has an abdominal mass, with no further workup or treatment desired by family. Resident has poor appetite, makes little effort to feed herself some meals. Family has stated she has lost weight. Goal: The resident will accept feeding assistance at meals as needed daily through review date. Interventions: Provide, Regular diet. Monitor intake and record q [every] meal, Resident will eat meals in the 2nd floor dining room. Staff to provide set up help, supervision, and feeding assistance at meals as needed. 4oz kemp+ [plus] time three with meds." The quarterly Minimum Data Set (MDS) dated 11/18/15 indicated R18 required supervision with eating, physical assist of one.
R22's care plan included, "The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] Dementia, Confusion, joint pain R/T [related to] arthritis. Residents cognition varies from day to day. Resident has full upper dentures and natural teeth on the bottom with some missing. Resident is at risk for falls R/T [related to] cognition, confusion increased weakness, and frequent complaints of dizziness, and history of frequent

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F 241	Continued From page 4 UTIs [urinary tract infections]. Resident is at risk for skin breakdown R/T [related to] decreased mobility and occasional incontinence. Interventions: EATING: The resident is able to feed self after set-up by staff ...The resident has nutritional problem or potential nutritional problem. She has chronic diagnoses of Lewy body dementia, psychosis, depression, anxiety ...Intake is 25% or less at many of her meals (she eats best at breakfast). Resident has experienced some weight loss since early October 2015. She had previously wanted to stay in the 120's ...She usually refuses staff assistance at meals. Interventions: Staff to provide set up help at meals as needed, cues to stay on task with eating, offer feeding assistance to finish meals ..." The change of condition MDS dated 12/16/15 indicated R22 required supervision, oversight, encouragement and cueing with eating, one person set up assist. R23's care plan included, "The resident has an ADL [activities of daily living] self-care performance deficit r/t [related to] Stroke, Dementia, Fatigue, Hemiplegia, Activity Intolerance, Limited Mobility. Intervention: EATING: Provide finger foods when the resident has difficulty using utensils. EATING: The resident is able to feed self after set up by staff ...The resident has nutritional problem or potential nutritional problem r/t [related to] chronic diagnoses of mild dementia, anxiety disorder, Hx [history] of TIA/CVA [mini stroke and stroke] with expressive aphasia and right side weakness. Intake varies, with many meals at 50% or less. Interventions: Staff to provide set up help and cues to stay on task at meals." The annual MDS dated 11/11/15 indicated R23 required supervision with eating, one person set up assist only.	F 241		

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F 241	Continued From page 5 On 03/02/2016 at 5:16 p.m. the director of nursing (DON) stated residents should be assisted to eat their food before it gets cold so it is pleasurable and tastes good. The DON stated the resident did not receive a very good dining experience and maybe we need to look at help for these people to see what level of assistance they require. I would like to see when there food comes in front of them they get the assistance to eat in a sufficient amount of time. The DON stated waiting twenty minutes to receive assistance to eat after their food was served would be way to long. The Combined Federal and State Bill of rights included, "The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her own individuality." R73 had been observed while eating in the third floor dining room on 3/1/16 at 11:43 a.m., R73 were seated at the same dining table. R73 was served her meal at 11:57 a.m. and nursing assistant (NA)-F assisted her to eat. During this meal, nursing assistant (NA)-F was seated next to R73 and had been observed wearing latex gloves on both hands while assisting R73 with eating her meal. NA-F never once had taken her gloves off during the entire meal. NA-F was not observed to have any open areas on her hands. During an observation of the morning meal on 3/2/16 at 8:23 a.m., both R73 and R58 were observed to be in the dining room. NA-F was observed to be wearing latex gloves on both hands while seated throughout the entire meal and had never taken off her gloves except when briefly leaving the table. R58 was observed to be	F 241		

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assisted by NA-G during the entire meal who had also worn latex gloves while assisting R58. Both nursing assistants did not appear to have any open areas on their hands. At one point during the meal NA-F had left the table to get a bowl. Before leaving, NA-F had taken off her gloves to leave the dining area. Upon returning, NA-F then proceeded to put latex gloves on both hands and once again assisted R73 with eating her meal.

During an observation on 3/2/16 at 12:10 p.m. both R73 and R58 were seated at the same table in the dining room. NA-F was observed to be assisting R73 with eating her meal. NA-F was observed to be wearing latex gloves while assisting R73. NA-G was observed to be assisted R58 and had been wearing latex gloves as well during the course of the meal.

When interviewed on 3/3/16 at 7:09 a.m., NA-G stated that she was told to wear gloves when seated at the dining table assisting residents to eat. NA-G stated that she had discussed this with a nurse and was told to wear the gloves when assisting residents to eat.

When interviewed on 3/3/16 at 8:21 a.m., NA-F stated that she had been told at a different facility to wear gloves while assisting residents to eat. NA-F stated that it was normal to wear gloves during meals while residents were assisted to eat meals.

When interviewed on 3/3/16 at 8:42 a.m., the Director of Nursing (DON) stated that the facility stressed the importance of wearing gloves. The DON stated that he attributed the fact that staff were wearing gloves during the entire meal was due to the nervousness of the staff with surveyors

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F 241	Continued From page 7 present. The DON stated that the facility always stressed that the staff were not to touch food with bare hands. As a precaution, the staff had worn gloves. Review of the facility policy titled, Dining (no date), it stated that the objective was to provide residents with a dignified meal service. It stated that staff were to wash their hands to prevent the spread of infection between assisting residents. It advised to follow proper infection control techniques at all times.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each	F 278		4/1/16

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F 278	Continued From page 8 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to identify broken carious teeth for an oral assessment for 1 of 2 residents (R5) reviewed for dental services. Findings include: R5's annual Minimum Data Set (MDS) dated 2/17/16, had identified for oral/dental status no oral concerns were present. R5's Admission Record, dated 3/3/16, identified diagnosis of type two diabetes mellitus. During observation on 3/1/16, at 9:36 a.m., surveyor viewed R5's teeth and noted no teeth on top of gum line, one tooth and broken carious teeth on R5's bottom gum line. During observation on 3/3/16, at 9:50 a.m., registered nurse (RN)-C verified R5 had broken carious teeth on his bottom gum line. On 3/3/16, at 9:50 a.m., RN-C stated she was responsible for completing the oral assessments for the MDS. RN-C stated she does not stick her hand in the resident's mouth and she had not visually looked at R5's teeth when she had completed the MDS. RN-C stated she had interviewed R5 and he had always told her I have one tooth. RN-C verified R5's annual MDS dated 2/17/16, identified no oral concerns were present.	F 278	It is policy of this facility that licensed nursing staff will provide accurate assessments of the resident□s oral status. Nurse failed to observe R (5)□s oral cavity during the oral assessment. She based her assessment on the interview of a resident who is independent with his cares. Because all residents receiving oral assessments are potentially affected by the cited deficiency on 3/3/2016, the director of nursing reviewed the assessment responsibilities with the MDS nurse immediately. MDS and care plan were corrected. To enhance currently compliant operations and under the direction of the director of nursing and the MDS nurse, nursing staff will receive in-service training regarding state and federal requirements for proper oral assessments. The training will emphasize the importance of proper oral assessments as indicated on the residents care plan and MDS. Effective 3/3/16, the QA committee will monitor assessments. The director of nursing, MDS nurse or designated quality-assurance representative will perform checking of assessments for all new residents and at all residents□ quarterly reviews to assure continued compliance. The findings of the quality	

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F 278	Continued From page 9 During interview on 3/3/16, at 11:15 a.m., the director of nursing stated he would expect a visual assessment be completed for an oral assessment and the findings of the assessment to be documented on the MDS. A facility policy for oral assessments was requested and the facility provided CMS's (Centers for Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2015, Section L: Oral/Dental Status, pages L-1, L-2 and L-3. The manual indicated Steps for Assessment 4. Conduct exam of the resident's lips and oral cavity with dentures or partial removed, if applicable, Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.	F 278	assurance checks will be documented and submitted at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		4/1/16

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F 279	Continued From page 10 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan related to pain for 1 of 5 residents (R39) reviewed for unnecessary medications. Findings include: R39 had been observed on 3/1/16, at 9:13 a.m., R39 had stated to licensed practical nurse (LPN)-A my back is hurting. LPN-A was observed to administer medication to R39. LPN-A stated she had given R39 Tylenol (pain medication). R39's physician orders dated 2/23/16, identified diagnosis of low back pain and revealed orders for Tylenol 650 mg (milligrams) every four hours as needed (PRN) for minor discomfort, Gabapentin (an anti-seizure drug used to treat pain) solution 250 mg/5 ml (milliliters) - give 2.5 ml every two hours PRN for anxiety/pain (may give up to three times per day), Tylenol 1000 mg every eight hours PRN for pain. The medication administration record dated 3/16, for R46 showed the medications were given as per the physician's orders. In addition, R39's progress note, dated	F 279	Resident R39□s comprehensive care plan was updated to include resident□s diagnosis and to follow physician orders for medication administration, labs and treatments, also to notify MD and family of any changes in health status. Pain was also addressed regarding resident has acute/chronic pain r/t headache, low back pain. Resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review dates. Because all residents receiving medications are potentially affected by the cited deficiency, on 3/3/16 the Director of Nursing reviewed all Care Plans and updated. To enhance currently compliant operations and under the direction of the director of nurses, the Resident Care Coordinators were educated on 3/3/16 regarding addressing diagnoses and pain on care plans and also nursing staff will receive educational training regarding state and federal requirements for minimizing occurrences. Part of the training will emphasize the importance of accurate care plans as	

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F 279	Continued From page 11 3/1/16, at 9:12 a.m., identified Tylenol 650 mg had been given to R39 for backache. R39's current care plan, failed to address the diagnosis of low back pain and pain management. On 3/3/16, at 10:15 a.m., registered nurse (RN)-A verified R39's care plan failed to address pain. On 3/3/16, at 1:18 p.m., the director of nursing stated I guess no, I do not expect pain to be care planned. The facility policy Care Plan, undated, indicated the interdisciplinary team determines problems to address on the resident's care plan. The resident's individual care plan must provide enough information to allow a caregiver to provide care without having to ask other staff about ADL (activities of daily living) procedures and preferences. Staff will provide care to the resident according to the resident ' s individualized care plan. Each resident's care plan will be reviewed that it is current.	F 279	indicated by resident□s diagnosis and goals. Effective 3/4/16 the quality-assurance program will track implementation under supervision of the Director of Nursing to monitor residents care plan. The director of nurses, MDS nurse or designated quality-assurance representative will perform the following systematic changes: checking all new resident□s care plan and at all residents□ quarterly review to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the care planed implementation of	F 282	Facility is to provide adequate tracking of supplemental nutritional intake. The way	4/1/16

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F 282	Continued From page 12 a nutritional supplement for 1 of 3 residents (R96) reviewed for nutrition. Findings include: R96's care plan, dated revision 12/12/15, identified the resident has nutritional problem or potential nutritional problem related to new admission following surgical repair of right femur fracture and has chronic diagnoses of dementia. Intake is variable. Total protein and albumin levels are low. Interventions included: provide resident with 4 ounces of Kemps (a nutritional supplement) two times per day at scheduled medication passes, provide diet as ordered, monitor intake and record every meal. R96's record failed to include documentation the Kemps was being given as per R96's care plan directed. On 3/3/16, at 8:50 a.m., the dietary director (DD)-D stated the recording of the Kemps should be on R96's medication administration record (MAR). The DD-D verified the Kemps was not on R96's MAR and R96's record failed to include documentation of the amount of intake for the Kemps. On 3/3/16, at 9:21 a.m., licensed practical nurse (LPN)-D stated she had administered R96's medications and confirmed she had not given R96 any Kemps when administering medications to R96. LPN-D reviewed R96's MAR and physician orders. LPN-D stated if the Kemps is not listed in the computer physician order record the Kemps would not show up on the MAR. LPN-D verified the Kemps was not on R96's MAR.	F 282	that this has been achieved for R96 is that the Kemps nutritional supplement has been placed on the resident□s Electronic Medical Record. When this supplement is given there has been a built in hard stop where the nurse cannot proceed until the amount has been recorded. Previously it was under the dietary supplement orders where it could not be tracked. Because all residents receiving nutritional supplements are potentially affected by the cited deficiency, on 3/7/16, the director of nursing reviewed all dietary supplement orders to ensure that documentation is to be addressed. To enhance currently compliant operations and under the direction of the director of nurses, all nursing staff will receive in-service training regarding state and federal requirements for minimizing documentation errors. The training will emphasize the importance of documenting intake amounts on all supplemental nutrition. Effective 3/4/16 the quality-assurance program will track implementation under supervision of the Director of Nursing to supplemental nutrition intake. The director of nurses, dietary director or designated quality-assurance representative will perform the following systematic changes: weekly checking of all new resident□s medication administration records and at all residents□ quarterly review to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for	

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F 282	Continued From page 13 On 3/3/16, at 9:28 a.m., LPN-B a resident care coordinator stated she would expect the Kemps to be on the MAR and the Kemps to be given as per plan of care. On 3/3/16, at 11:05 a.m., the director of nursing (DON) stated the reason the supplement was not being documented on the MAR was due to a computer problem. The DON stated he would of expected dietary to identify the supplement was not being given. The facility policy Care Plan, undated, indicated the interdisciplinary team determines problems to address on the resident's care plan. The resident's individual care plan must provide enough information to allow a caregiver to provide care without having to ask other staff about ADL (activities of daily living) procedures and preferences. Staff will provide care to the resident according to the resident's individualized care plan. Documentation must be done as often as needed for assessment purposes as indicated by the resident's condition.	F 282	further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309		4/1/16

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F 309	Continued From page 14 by: Based on observation, interview and document review, the facility failed to monitor a bruise for 1 of 3 residents (R61) reviewed for skin conditions (non-pressure related). Findings include: R61 was observed on 3/1/16 at 8:48 a.m., R61 was observed to have a bruise on the top part of his right hand. It was approximately the size of an orange. R61's admission record, dated 9/9/2014, indicated that the resident had diagnoses of: long term use of anticoagulants; atrial fibrillation; anemia; cerebral infarction due to unspecified occlusion or stenosis of an unspecified cerebral artery. R61's order summary report, dated 2/24/16, indicated that the physician had prescribed Coumadin (a blood thinning medication) 1 mg (milligrams) 1 tablet by mouth in the evening. R61's care plan, dated 1/12/16, stated that the resident was taking Coumadin. It stated that he was at risk for side effects due to Coumadin usage. The care plan recommended R61's that staff monitor for signs and symptoms of bleeding. R61's medication administration report (MAR), reviewed from 2/1/16 through 3/3/16, indicated that the resident had been receiving a 1 mg dose of Coumadin by mouth in the evening. R61's progress notes, reviewed from 2/1/16 through 3/3/16, indicated a skin/wound note on 2/15/16. It stated, "Resident wheeled out to the	F 309	It is the policy of the facility to provide adequate monitoring of all bruising. R61 was immediately assessed on 3/4/16 any alterations in skin condition were addressed by licensed nurse. Treatment was set up to monitor bruise until resolved. Resident care coordinator reviewed and updated care plan with his risk of bruising due to his Coumadin use. 3/3/16 staff was educated by Resident Care Coordinator on monitoring all bruises for R61 and all residents until bruise has resolved. DON will lead interdisciplinary team to address incident reports to ensure proper monitoring is being done. To enhance currently compliant operations and under the direction of the director of nurses, all nursing staff will receive in-service training regarding state and federal requirements for minimizing documentation errors. The training will emphasize the importance of documenting intake amounts on all supplemental nutrition. Effective 3/4/16 the quality-assurance program will track implementation under supervision of the Director of Nursing to track monitoring of bruises. The director of nursing, or designated quality-assurance representative will perform the following systematic changes: weekly checking of all new resident□s treatment records and for all residents at their quarterly review to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for	

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F 309	Continued From page 15 nurse's station from dining room after breakfast. Resident had a skintear 4 cm [centimeter] by 0.5 cm on the posterior side of right hand. Resident said, 'I was wheeling away from table and my hand cut the table.' Resident's right hand was cleansed with wound cleanser; 3 half steri-strips applied, and no telfa pad and rolled gauze with tape used to cover skintear." On 2/16/16, R61's doctor had been notified of the skin tear asking for any recommendations. The response from the doctor advised to continue to monitor until the skin tear was healed. No further progress notes alluded to the skin tear or any further monitoring. R61's treatment administration record (TAR), dated 2/16/16, stated that staff were to monitor the resident's skin tear to his right hand until it was resolved. His right hand was to be checked one time a day for fourteen days. The nursing staff were to cleanse the area daily and monitor for infection. From 2/19/16 through 2/26/16 the staff did not document that this had been done. When interviewed on 3/3/16 at 7:23 a.m., licensed practical nurse (LPN)-D stated that the bruising on R61's right hand probably was the result of a bump. LPN-D stated that when a bruise was first observed, the nursing assistants were trained to notify the nurses where it then is documented and placed on the treatment administration record in order to monitor it. LPN-D stated that there is no minimum size threshold, the staff document and record all bruises. When interviewed on 3/3/16 at 7:52 a.m., LPN-C observed the bruise on R61's right hand. LPN-C stated that the size looked to be approximately 3 cm (centimeters) by 2 cm. LPN-C stated that	F 309	further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	

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F 309	Continued From page 16 when a bruise was first noticed, an incident report was filled out, then the family was to be notified. The resident's physician was also notified requesting any orders. Also, the bruise was documented and the bruise was to be monitored until resolution. LPN-C stated that R61 had a bruise on his right hand. She stated that no incident report had been filed regarding the bruise. When interviewed on 3/3/16 at 8:35 a.m., the director of nursing stated that any resident who had received a bruise should be identified and monitored until the bruise was resolved. A copy of the facility's skin monitoring policy was requested. The facility provided a copy of the policy titled, "Wound Care Nursing Documentation (4/30/14)." Does not specifically address bruising.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 315	It is the policy of this facility to document	4/1/16

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F 315	Continued From page 17 review, the facility failed to provide a medical justification for the ongoing use of an indwelling catheter for 1 of 3 residents (R61) reviewed for urinary catheter use and failed to comprehensively assess bladder status for 1 of 2 residents (R96) reviewed for urinary incontinence. Findings include: LACK OF CLINICAL JUSTIFICATION FOR CONTINUED USE OF INDWELLING URINE CATHETER: R61's admission record, dated 9/9/14, indicated diagnoses of urine retention and chronic kidney disease. R61's order summary report, dated 8/24/15, indicated that the resident was to have his foley catheter (can stay in place for a period of time used to drain urine) changed as needed or every sixty days. On 11/25/15, the physician ordered that R61's foley catheter bag be changed every two weeks. On 11/28/15, the physician ordered that the foley catheter be changed every month. R61's care plan, dated 1/12/16, stated that the resident has an indwelling foley catheter related to urinary retention. It stated that the resident was at risk of developing urinary tract infections (UTI) related to the catheter. It advised foley catheter care every shift. It advised the encouragement of fluids. Staff were to provide perineal cares with toileting and incontinent episodes. Staff were to monitor for signs and symptoms of a UTI. R61's annual Minimum Data Set (MDS), dated 12/30/15, indicated that the resident had an indwelling urinary catheter.	F 315	clinical justification for continued use of indwelling urinary catheter. Director of Nursing on 3/4/16 contacted R 61□s primary physician regarding: clinical justification for continuous indwelling catheter. Received clinical note from primary on 3/21/16 citing specific reasons and justification as to why catheter should be continued. To enhance currently compliant operations and under the direction of the director of nurses, resident care coordinators and licensed staff were educated on 3/4/16 regarding required documentation for chronic indwelling catheters. Effective 3/4/16 the quality-assurance program will track implementation under supervision of the Director of Nursing for required documentation for indwelling catheters. The director of nursing or designated quality-assurance representative will perform the following systematic changes: checking of new resident□s documentation for ongoing use of Foley catheter and at all residents□ quarterly review to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review or corrective action. It is the policy of this facility to comprehensively assess bladder function with significant changes and annual assessments. For resident R 96 a comprehensive bladder assessment was completed on 3/4/16 and care plan was updated by resident care coordinator.	

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F 315	Continued From page 18 When interviewed on 3/1/16 at 10:43 a.m., licensed practical nurse (LPN)-D stated that R61 had an indwelling urinary catheter due to a diagnosis of urinary retention. LPN-D showed this surveyor a list of R61's diagnoses. It contained the diagnosis urinary retention. R61's hospital visit, dated from 5/18/15 through 5/26/15, indicated that R61 had a urinary tract infection related to an indwelling foley catheter. R61 had a fever and brown urine. He was admitted due to the fever and brown urine; he also had bacteria in his urine related to the indwelling foley catheter. R61 completed a course of antibiotics during his hospital stay. R61's indwelling foley catheter was changed during his hospital stay. It stated that ongoing foley care was to be resumed at R61's nursing home. R61's follow-up hospitalization visit, dated 6/30/15, indicated that the resident was in the hospital from 5/18/16 through 5/26/16 for a urinary tract infection (UTI) related to a chronic indwelling foley catheter. R61 had completed a course of Levaquin (an antibiotic). R61's progress note, dated 11/9/15, stated that the resident was treated with Levaquin (an antibiotic) 500 mg for signs and symptoms of a urinary tract infection (UTI). R61 had cloudy urine with a large amount of sediment. R61 also had increased confusion. When interviewed on 3/2/16 at 4:59 p.m., registered nurse (RN)-F stated that R61 has had the indwelling catheter ever since she had been working at the facility. RN-F stated that the resident had urinary retention and chronic kidney	F 315	Resident Care Coordinators were educated on proper state and federal regulations regarding proper evaluations for significant changes in resident□s condition. To enhance currently compliant operations and under the direction of the director of nurses, all nursing staff will receive in-service training regarding state and federal requirements for minimizing documentation errors. Effective 3/4/16 the quality-assurance program will track implementation under supervision of the Director of Nursing for completion of bladder assessments. The director of nursing or designated quality-assurance representative will perform the following systematic changes: checking all new residents□ bladder assessments and at all residents quarterly review to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	

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disease. RN-F stated that R61 had a slit on his penis so the nursing staff were to make sure that the catheter did not pull on the resident.

When interviewed on 3/3/16 at 7:52 a.m., licensed practical nurse (LPN)-C stated that R61 had an indwelling catheter in place as long as she has worked at the facility. LPN-C stated that the facility did attempt to remove the catheter at one point but it was not successful. LPN-C stated that R61 could have possibly had the catheter due to his previous stroke which occurred prior to his living at the facility.

When interviewed on 3/3/16 at 9:29, licensed practical nurse (LPN)-B was requested to provide any documentation that justified the continue use of an indwelling foley catheter. LPN-B stated that the facility did attempt to remove the catheter at one point. LPN-B stated that when they facility tried, R61 could not pass any urine at all. LPN-B provided the following documentation to justify the continued use of an indwelling foley catheter: "11/18/14- the staff would like to try (sic) discontinue res foley catheter. May we have permission to do so. What kind of schedule do you suggest." In response, the facility's nurse practitioner would review with R61's physician. On 11/23/14, the progress notes stated, "Received t.o. (telephone order) to reinsert foley cath (sic) and notify (the doctor) that removing cath (sic) did not work."

When interviewed on 3/3/16 at 12:36 p.m., registered nurse (RN)-D and licensed practical nurse (LPN)-B stated that the progress note dated to 11/18/14 was the last time R61's catheter had been addressed and whether it should continue to remain. RN-D stated that she

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would have expected that a medical justification to continue with an indwelling foley catheter would have been addressed again.

When interviewed on 3/3/16 at 12:45 p.m., the director of nursing (DON) stated that the he could not disagree with the decision by the physician to resume the continued use of an indwelling foley catheter. He referenced R61's last hospital stay, dated from 5/18/15 through 5/26/15. It stated that ongoing foley care to be resumed at Lakeview Nursing Home. He stated that the diagnosis of urinary retention should be good enough justification.

The document titled, "Use of an Indwelling Urinary Catheter (no date)," addressed factors that predispose the resident to the use of an indwelling catheter. If an indwelling catheter was to be deemed medically justified beyond fourteen days of use, it advised to restrict the use of a catheter to urinary retention that cannot be treated or corrected medially or surgically. It advised if an indwelling catheter was not medically justified, the catheter was to be removed and document the trial removal; complete a voiding trial; determine the best bladder management program for the resident; provide education to the resident and family regarding the risk versus benefit for the use of catheters; encourage and praise the resident with successful voiding.

LACK OF A COMPREHENSIVE BLADDER ASSESSMENT TO DETERMINE INTERVENTIONS TO MAINTAIN OR IMPROVE INCONTINENCE:

R96's significant change in status Minimum Data Set (MDS) dated 1/13/16 indicated R96 was

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frequently incontinent (this was a decline for R96) of urine, was not on a toileting program and required extensive assistance to toilet. However, the admission MDS dated 12/17/15, indicated R96 was occasionally incontinent of urine and was not on a toileting program.

R96's continence evaluation, dated 12/11/15, indicated diagnoses of fractured hip, dementia and arthritis. Medications resident is taking: diuretic, antidepressant and narcotics. Aware of urge to void: occasionally. Able to find toilet: no. Able to understand reminders and prompts: yes. Can ask for assistance: yes. Type of incontinence: mixed. Uses incontinent pads. R96's record failed to include a continence evaluation for the significant change in status MDS dated 1/13/16.

R96's care plan, dated 12/11/15, indicated the resident has an ADL (activities of daily living) self-care performance deficit related to stroke, dementia, musculoskeletal impairment, limited mobility and confusion. Interventions included toilet use: the resident is totally dependent on one to two staff for toilet use and Transfer: the resident is totally dependent on one to two staff with EZ-stand (mechanical lift) for transferring.

The nursing assistant care sheet for R96, dated 3/2/16, failed to address toileting for R96.

R96's record failed to include an assessment of R96's urinary continence status, which included individualized programming and interventions to maintain as much normal bladder function as possible

On 3/3/16, at 7:50 a.m., licensed practical nurse

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(LPN)-C when queried regarding toileting for R96, stated R96 sometimes puts on her call light, but not always. LPN-C stated R96 will put on her call light and forget what she puts the call light on for.

On 3/3/16, at 9:47 a.m., registered nurse (RN)-C stated direction on how often to toilet R96 should be on the care plan and on the nursing assistant care sheets.

On 3/3/16, at 10:55 a.m., licensed practical nurse LPN-B stated she is not aware of an assessment and analysis being done from R96's continence evaluation dated 12/11/15. LPN-B stated R96 does not always know when to ask for the toilet. R96's cognition varies day to day. LPN-B verified R96's care plan failed to include interventions of when R96 should be toileted. LPN-B stated it would be her responsibility to care plan toileting for R96 and registered nurse (RN)-A would be responsible for the bladder assessment and analysis for R96.

On 3/3/16, at 11:13 a.m., the director of nursing stated he would expect there to be a follow up of the data from the bladder evaluation to see how we can help R96.

The facility policy Bowel and Bladder Evaluation, dated revision 4/29/14, indicated the facility will ensure that each resident with bowel and bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. Each resident will be assessed for bowel and bladder voiding patterns on admission, quarterly, and with a significant change with evaluation for feasibility in retraining for bowl and/or bladder control. The licensed nurse will gather information from the

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F 315	Continued From page 23 chart, the resident's family/representative, staff members, from resident. RCC's will use information to complete the bowel evaluation and bladder evaluation forms. The resident's plan of care will be developed to address the issue, goals and appropriate interventions.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to address a severe weight loss for 1 of 3 residents (R96) reviewed for nutrition. Findings include: R96's admission Minimum Data Set (MDS) dated 12/17/15, identified a weight of 212 pounds, weight gain of 5 percent or more in the last month. R96's 5 day MDS dated 1/29/15, identified a weight of 173 pounds (this was a 39 pound weight loss in 12 days), weight loss of five percent or more in the last month or loss of 10	F 325	R 96 was found to not be monitored for significant weight loss. The certified dietary manager and nursing administration will meet as part of the interdisciplinary team and discuss at morning standup meetings (Monday □ Friday) any changes of concern such as weight loss. On 3/4/16 Resident Care Coordinators and licensed nursing staff were educated on proper state and federal regulations regarding proper evaluations for significant weight loss. Nurse practitioner was updated on 3/4/16 to R 96□s weight concerns, weight has	4/1/16

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F 325	Continued From page 24 percent or more in the last six months and required set up assist to eat. R96 experienced a 39 pound weight loss (18.4 percent loss) in less than 60 days after admission, according to the MDS dated 1/29/15 (severe or greater than 5.0 percent in one month and/or severe or greater than 7.5 percent in three months). On 3/2/16, at 11:38 a.m., observation revealed R96 eating independently and had eaten 100 percent of cheesecake, tomatoes, bun, 50 percent of hot dish and drank 100 percent of milk and coffee. R96's care plan, dated revision 12/12/15, identified the resident has nutritional problem or potential nutritional problem related to new admission following surgical repair of right femur fracture and has chronic diagnoses of dementia. Intake is variable. Total protein and albumin levels are low. Interventions included: provide resident with 4 ounces of Kemps (a nutritional supplement) two times per day at scheduled medication passes, provide diet as ordered (regular), monitor intake and record every meal. Staff to provide set up help at meals as needed, also provide verbal encouragement to eat. The resident has an ADL [activities of daily living] self-care performance deficit related to stroke, dementia, musculoskeletal impairment, limited mobility and confusion, with intervention of Eating: The resident is able to feed self after set up by 1 staff. However, there is no documentation that Kemps supplement was being given as per R96's care plan directed. 12/12/2015 Nutrition/Dietary Note: Initial nutrition	F 325	stabilized. Nurse practitioner was not concerned with the weight loss due to the amount of edema resident was admitted with. Staff educated on proper notification of Dietary Director and physician in regards to significant weight loss on all residents. To enhance currently compliant operations and under the direction of the director of nurses, all nursing staff will receive in-service training regarding state and federal requirements for minimizing documentation errors. Effective 3/4/16 the quality-assurance program will track implementation under supervision of the Director of Nursing for residents with significant weight loss. The director of nursing or designated quality-assurance representative will perform the following systematic changes: weekly checking of all new resident□s weights and for all residents at their quarterly review to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	

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assessment. 86 years old. Recently hospitalized for surgical repair of a femur FX [fracture]. Chronic diagnoses include dementia, normal pressure hydrocephalus, HX [history] of TIA, macular degeneration, hypertension, hyperlipidemia, atrial fib, and osteoarthritis. Is on a regular diet. No chewing or swallowing problems. She is able to feed herself after set up help is provided. Intake has been variable, with half her meals so far at 50 percent or less and half at 51 to 100 percent. Her weight on her admission to the hospital was about 198 pounds and the hospital RD wrote that she had not had any recent weight loss. She was 210 pounds on admission here, most likely due to edema. She was documented with two to three plus pitting edema in her lower legs on admission. She was receiving Ensure BID [twice daily] in the hospital per RD note there. I am going to start her on four ounces Kemps BID at scheduled medication passes.

12/21/2015 Nutrition/Dietary Note: 5 day new admission: Completed MDS and CAA (Care Area Assessment). Note that her weight is down to 184.5 pounds after her assessment period. Her intake is variable yet but she has already been started on Kemps 4 ounces BID with medication passes. Will suggest that staff look closely at her next weight.

R96's significant change MDS dated 1/13/16, indicated a weight loss.

1/19/2016 Nutrition/Dietary Note: Significant change assessment: Diet: Regular Wt. (weight) has shown a loss from admit. Wt. on 1-12-2016 was 176.2 Wt. on 12-10-2015 was 210.0. Kemp+ 4oz with meds. She feeds self 76 to 100 percent.

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Skin good. Trigger K0310 [weight gain from the MDS] no refer. Dietary will continue to follow care plan and monitor.

2/21/2015 Nutrition/Dietary Note: 5 day new admission: Completed MDS and CAA. Note that her weight is down to 184.5 pounds after her assessment period. Her intake is variable yet but she has already been started on Kemps 4 ounces BID with medication passes. Will suggest that staff look closely at her next weight.

R96's physician progress notes dated 1/27/16 and 2/16/16, failed to address R96's weight loss.

R96's weights and vitals summary identified the following weights in pounds:

3/1/2016 179.8
2/23/2016 182.2
2/19/2016 181.4
2/9/2016 174.4
2/5/2016 175.1
1/22/2016 172.7 (a severe weight loss)
1/12/2016 176.2
1/8/2016 179.3
1/5/2016 176.0
12/19/2015 184.5
12/11/2015 211.6
12/10/2015 210.0

R96's record failed to include documentation of a review by the facility registered dietician regarding the weight loss and notification of R96's primary physician and family regarding the weight loss. In addition, the record lacked documentation of interventions implemented related to the weight loss, if there was a discrepancy in weights for R96 and explanation of the discrepancies or

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documentation indicating the resident could not attain or maintain acceptable parameters of nutritional status.

On 3/3/16, at 8:50 a.m., the dietary director (DD)-D stated the registered dietician (RD)-E had last assessed R96 12/21/15 and R96's weight was 184.5. The 12/12/15 assessment identified weight of 210 and R96 had two to three plus edema in lower legs. R96 was receiving four ounces of Kemps BID. The DD-D stated RD-E has not assessed R96 after 12/21/15, usually she would increase the Kemps. The DD-D stated the physician is probably not aware of the weight loss unless nursing had notified the physician. The DD-D stated she was not aware of R96's weight going down to 175 on 2/5/16 and she questions if the weight was accurate. The DD-D stated usually the nurse gives a heads up if there is a weight loss. The RD-E completes the CAA's and I complete the MDS. The DD-D stated the recording of the Kemps should be on R96's medication administration record (MAR). The DD-D verified the Kemps was not on R96's MAR and R96's record failed to include documentation of the amount of intake for the Kemps. The DD-D stated RD-E is at the facility once weekly. The DD-D stated RD-E had a weight of 175 written down in the notes, I do not know why she did not compare the weight to the 12/15 weight of 210. The DD-D stated she had documented the note dated 1/1916.

On 3/3/16, at 9:07 a.m., the RD-E stated she could not remember if she had been informed if R96 was a weight loss. The RD-E stated if the dietary manger stated my last assessment was 12/21/15, then I must not have completed an assessment after that date.

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F 325	Continued From page 28 On 3/3/16, at 9:21 a.m., licensed practical nurse (LPN)-D stated she had administered R96's medications and confirmed she had not given R96 any Kemps when administering medications to R96. LPN-D reviewed R96's MAR and physician orders. LPN-D stated if the Kemps is not listed in the computer physician order record the Kemps would not show up on the MAR. LPN-D verified the Kemps was not on R96's MAR. On 3/3/16, at 9:28 a.m., licensed practical nurse (LPN)-B stated R96 was admitted post-surgical and had edema. LPN-B reviewed R96's notes and stated the first care conference in January 2016 does not address weight loss. LPN-B stated I know R96's appetite is not very good. LPN-B stated she had not informed the physician of R96's weight loss. LPN-B verified R96's physician progress notes as above do not address weight loss. LPN-B stated the nurse on the floor is responsible to notify her of weight loss, the physician and dietary. LPN-B stated she would expect the Kemps to be on the MAR and the Kemps to be given as per plan of care. On 3/3/16, at 11:05 a.m., the director of nursing (DON) stated he did not remember anyone informing him R96 had weight loss. The Don stated he would expect nursing to notify regarding significant weight loss and inform the physician. The DON stated the reason the supplement was not being documented on the MAR was due to a computer problem. The DON stated he would of expected dietary to identify the supplement was not being given. The facility policy Weight Monitoring Nursing	F 325		

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F 325	Continued From page 29 Services, undated, identified it is the policy of this facility to monitor residents weights from the time of admission and to provide interdisciplinary support and/or intervention to avert adverse trends. Procedure: C. Weight monitoring procedure: Licensed Nurse's role 2. The licensed nurse will analyze the resident's weight to identify variances and trends over periods of days, weeks, or months as appropriate to the resident. Nursing staff will notify licensed dietician of changes. Also the dietician will have access to weights in point click care. 3. The licensed nurse will initiate a nutritional risk care plan (or update existing one). 4. The licensed nurse will notify the physician and the dietician of variances the same day the weight is taken, and document the notification on the weight record, point click care will signify any weight changes. 5. Licensed nurse will note any known contributing factors, such as increased diuretics or Wight loss program. Note: the presence of contributing factors does not eliminate the need to notify the physician and the dietician. 6. Based on the outcome of the thorough assessment, decisions will be made regarding the need for daily or weekly weights and other interventions as appropriate. The licensed nurse will update the residents care plan, in consultation with the physician and the dietician as appropriate.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		4/1/16

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F 329	Continued From page 30 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to document non-pharmacological interventions and reason for use for as needed (PRN) psychotropic and pain medications for 3 of 5 residents (R8, R39 & R61); in addition the facility failed to ensure a sleep assessment and analysis was completed to determine if a sleep medication was effective for 2 of 5 residents (R8, R39) who received a hypnotic for sleep; lastly, the facility failed to identify resident specific behaviors to determine if an antianxiety medication (Ativan) was affective for 1 of 5 residents (R61) reviewed for unnecessary medications; lastly, the facility failed to monitor a cardiac medication to determine if it is affective or showing side affects for 1 of 1 resident (R69) who receives Digoxin.	F 329	It is policy of this facility that nursing staff will document non-pharmacological interventions for psychotropic and pain medications. Resident R8 was receiving Ativan, Oxycodone, Tylenol, and Trazadone as PRN medications. With the electronic medication administration system we were able to place hard stops within the system to make sure non-pharmacological interventions were completed and documented for all of these medications. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to non-pharmacological interventions. R 8□s care plan was updated for	

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F 329	Continued From page 31 Findings Include: LACK OF NON-PHARMACOLOGICAL INTERVENTIONS AND IF AFFECTIVE TO RELIEVE PAIN AND ANXIETY: R8 was admitted to the facility on 12/6/2010 with diagnoses including: backache unspecified, abdominal pain unspecified and depressive disorder per the face sheet. R8's current physician orders dated included as needed (PRN) orders for the following psychotropic and pain medications: "Ativan Tablet 0.5 MG [milligrams] (Lorazepam); Give 1 tablet by mouth every 6 hours needed for anxiety related to Anxiety Disorder Unspecified; see non-medicated prevention sheet before giving the med [medication]." "Acetaminophen Tablet; Give 650 MG by mouth every 4 hours as needed for elevated temp (101-102 F), headache or minor discomfort, may also be given by rectal suppository." Review of the March 2016 medication administration record showed the following: R8 received PRN Ativan four times from 3/1/16 to 3/3/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R8 received PRN acetaminophen three times from 3/1/16 to 3/3/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN	F 329	non-pharmacological sleep, pain and psychotropic interventions specific to the resident. Due to resident being on Trazadone a sleep study was initiated on 3/4/16. Resident R 39 is receiving Seroquel, Tylenol, Gabapentin. With the electronic medication administration system we were able to place hard stops within the system to make sure non-pharmacological interventions were completed and documented for all of these medications. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to non-pharmacological interventions. R 39□s care plan was updated for non-pharmacological sleep, pain and psychotropic interventions specific to the resident. Due to resident being on Trazadone a sleep study was initiated on 3/4/16. R 61 is receiving Tramadol and Ativan. With the electronic medication administration system we were able to place hard stops within the system to make sure non-pharmacological interventions were completed and documented for all of these medications. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to non-pharmacological interventions. R 61□s care plan was updated for non-pharmacological pain and psychotropic interventions specific to the resident. R 61□s primary physician Dr. Green was contacted and he provided	

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F 329	Continued From page 32 acetaminophen being administered. Review of the February 2016 medication administration record showed the following: R8 received PRN Ativan sixteen times from 2/1/16 to 2/29/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R8 received PRN acetaminophen thirteen times from 2/1/16 to 2/29/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered. Review of the January 2016 medication administration record showed the following: R8 received PRN Ativan forty-one times from 1/1/16 to 1/31/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R8 received PRN acetaminophen twelve times from 1/1/16 to 1/31/16 with no documentation of reason to give the medication (no pain scale used) and no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered. R8's care plan included non-medical interventions for use for PRN Ativan however there was no	F 329	documentation to justify use of PRN Ativan. R 69 is receiving Digoxin every other day. At time of survey no documentation of pulse was recorded consistently with the medication administration. With the electronic medication administration system we were able to place hard stops within the system to make sure pulse is documented each time medication is given. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to medication administration and supplemental documentation. Going forward all residents receiving PRN pain, psychotropic and sleep medications will have non-pharmacological intervention documentation built into the resident□s MAR. Sleep medications will require a sleep study for all residents. Any resident on Digoxin will have pulse monitored and documented with administration. To enhance currently compliant operations and under the direction of the director of nurses, all nursing staff will receive in-service training regarding state and federal requirements medication administration and supplemental documentation. Effective 3/4/16 the Interdisciplinary Team will track implementation under supervision of the Director of Nursing to track medication administration and supplemental documentation for cited medications and will monitor that sleep studies are completed. The IDT will	

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F 329	Continued From page 33 indication they were used before giving medication as follows: 1. Offers reassurance 2. Listen and allow res to vent 3. Assess pain 4. Assess bowel issues 5. Offer food and fluids R8's care plan also indicated R8 was often uncooperative with non-medicated interventions, will tell staff, "don't ask me that again, just give me my pills", "I just want my pills." However, there was no indication that the current care plan interventions were affective or a reassessment of pain to determine new interventions for treating pain. On 3/03/2016, at 10:52 a.m. the director of nursing (DON) stated staff should attempt non-pharmacological intervention for the use the PRN medication whenever possible, staff should document the reason the medication was being given and if the medication was effective. On 3/03/2016, at 11:34 p.m. the DON stated the facility started documenting behaviors and PRN medication administration in point click care starting in January 2016. The DON told writer I would not find any documentation of non-pharmacological interventions being documented in the medical record since the system was changed to point click care. On 3/03/2016, at 11:55 a.m. licensed practical nurse (LPN)-A stated she attempted non-pharmacological interventions, would document the reason the medication was being given and stated she would go back after a half an hour to check to see if the medication worked	F 329	perform the following systematic changes: weekly checking for all new resident□s medication and sleep records and at all residents□ quarterly review to assure continued compliance. The quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	

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when she administered PRN medications. LPN-A stated she documented the non- pharmacological interventions attempted prior to administration of the medication in the nurse notes, "although I do know my residents pretty well. There are some of them you know you can offer non-pharmacological interventions and you know they just won't accept them. LPN-A stated you can suggest to R8 to go to the bathroom, try to eat something, and R8 will continuously put the call light on and ask for her scheduled oxycodone, her prn Tylenol and prn Ativan."

On 03/03/2016, at 1:11 p.m. registered nurse (RN)-A stated with the new computer system there was not a place to document the non-pharmacological intervention attempted prior to administration of the PRN Ativan, however stated the nurses should then document in the progress notes. RN-A stated the previous system used prompted staff to document non-pharmacological interventions attempted and the reason medication was given. RN-A confirmed the facility staff were not following the care plan to offer non-pharmacological interventions as R8 would consistently refuse them, become very upset and accusatory towards staff when attempted.

The Psychotropic (Psychoactive) Drug Use and Documentation procedure dated 12/29/13 instructed staff, "...Psychoactive drugs are used only in the resident's best interest, never for the convenience of staff or as punishment. Non-drug approaches and interventions and/or drug therapy are used whenever possible." The procedure instructed staff to...8. If psychotropic drugs are administered on a prn [as needed] basis, document on the back of the medication form the

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F 329	Continued From page 35 drug and the amount given, the targeted behavior, and the effectiveness of the drug. If necessary, document more specifically in the nurses' notes..." The Pain Evaluation and management policy dated 11/26/2012 instructed staff to, "...4. PRN medication that is given will be signed off on the PRN sheet and information supporting the use of the medication and its effectiveness will also be documented..." LACK OF COMPREHENSIVE SLEEP ASSESSMENT AND ANALYSIS TO JUSTIFY THE USE OF A SLEEP MEDICATION: R8's admission record revealed R8 was admitted on 2/6/2010 with diagnoses of depressive disorder. The quarterly Minnesota Data Assessment (MDS) dated 12-9-15, indicated R11 did not display behavior problems and did have difficulty sleeping, feeling tired or having little energy. R8's signed physician orders dated 1/14/16 included Trazodone 50 milligrams (mg) by mouth daily for insomnia. R8's care plan did not include non-pharmacological interventions for sleep. R8's behavior monthly flow sheets were reviewed for January 2016, February 2016 and March 2016 and revealed R8 had no documented concerns with insomnia. On 3/02/2016 3:29 p.m. registered nurse (RN)-A stated tracking the sleep pattern on the behavior sheets was the sleep assessment completed by	F 329		

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F 329	Continued From page 36 the facility. RN-A stated the facility completed sleep evaluations upon admission, upon start of a medication or if the pharmacist requested a sleep evaluation. RN-A stated she reviewed sleep on a quarterly basis based on the documentation of the behavior monthly flowsheets and also listened to the overnight report every day. RN-A stated there were not any non-pharmacological interventions developed as a part of R8's care plan for sleep as the Trazodone was scheduled to be given daily. On 03/03/2016, at 9:56 a.m. registered nurse (RN)-A stated staff track R8's insomnia of the behavior tracking sheets. RN-A confirmed the behavior monthly flow sheets provided for January 2016, February 2016 and March 2016 revealed R8 had no documented concerns with insomnia. RN-A stated staff just know her (R8) and her sleep patterns. RN-A stated another nurse in the facility had completed two comprehensive sleep assessments for R8, however unable to provide to surveyor for review. A policy and procedure was requested for comprehensive sleep assessment and was not provided. R39's Admission record dated 3/3/16, identified diagnoses of low back pain, delusional disorders, major depressive disorder, psychotic disorder with hallucinations due to known psychological condition, anxiety, dementia, and personality disorder. R39's quarterly MDS dated 1/20/16, indicated R39 had verbal behaviors, received scheduled and as needed (PRN) pain medications, received no non-pharmacological interventions for pain, received antipsychotic and antidepressant medications.	F 329		

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F 329	Continued From page 37 R39's current physician orders dated 2/23/16, included PRN orders for the following psychotropic and pain medications: Seroquel 50 mg, one tablet as needed (PRN) for behaviors/delusions related to delusional disorders, major depressive disorder, psychotic disorder with hallucinations due to known physiological condition. Acetaminophen (Tylenol) 650 mg every four hours PRN for elevated temp (101-102 F), headache or minor discomfort, may also be given by rectal suppository. Tylenol 1000 mg every eight hours PRN for pain. Gabapentin (an anti-seizure drug used to treat pain) solution 250 mg/5 ml (milliliters), give 2.5 ml every two hours PRN for anxiety/pain (may give up to three times per day). Review of the March 2016 medication administration record (MAR) and progress notes showed the following: R39 had received Seroquel PRN one time on 3/1/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Seroquel being administered. R39 had received Tylenol (acetaminophen) PRN three times from 3/1/16 to 3/2/16 with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered for 3 of 3 doses. R39 had received Gabapentin one time on 3/2/16	F 329		

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F 329	Continued From page 38 with no documentation of non-pharmacological interventions attempted prior to the PRN Gabapentin being administered. Review of the February 2016 MAR and progress notes showed the following: R39 had received Seroquel PRN 10 times, with no documentation of the reason to give the medication for four out of 10 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN Seroquel being administered for 10 out of 10 doses. R39 had received Tylenol (acetaminophen) PRN 15 times, with no documentation of the reason to give the medication for nine out of 15 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered for 15 out of 15 doses. R39 had received Gabapentin seven times, with no documentation of the reason to give the medication for three out of seven doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN Gabapentin being administered for seven out of seven doses. Review of the January 2016 MAR and progress notes showed the following: R39 had received Seroquel PRN 14 times, with no documentation of the reason to give the medication for four out of 14 doses administered and with no documentation of	F 329		

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F 329	Continued From page 39 non-pharmacological interventions attempted prior to the PRN Seroquel being administered for 14 out of 14 doses. R39 had received Tylenol (acetaminophen) PRN 17 times, with no documentation of the reason to give the medication for seven out of 17 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered for 17 out of 17 doses. R39 had received Gabapentin 10 times, with no documentation of the reason to give the medication for three out of 10 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN Gabapentin being administered for 10 out of 10 doses. R39's care plan included non-medical interventions for use for PRN psychotropic medications as follows: 1. Assess pain 2. Offer reassurance, listen to concerns 3. Toilet resident 4. Reorient as needed 5. Provide for resident safety 6. Take resident to activity, 1-1 if possible 7. Assess food and fluid needs 8. Ease anxiety by bringing resident to ice machine R39's care plan failed to address pain management including non-medication interventions to be attempted first before giving pain medication to control pain. On 3/3/16, at 10:15 a.m., RN-A verified chronic	F 329		

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pain was not addressed on R39's care plan. RN-A verified reasons for giving and non-pharmalogical interventions prior to administration of PRN psychotropic medications and PRN pain medications was not being documented. RN-A stated she would absolutely expect non-pharmalogical interventions to be offered as per the plan of care.

On 3/3/16, at 11:18 a.m., the DON stated the goal is to offer non-pharmacological measures before giving a PRN medication. I think the breakdown is when we went to point click care (computer program), then the offer of non-pharmalogical measures stopped being done. I would expect the reason the medication was being given to be documented.

The facility Pharmaceutical Services Policy and Procedure Manual 5.30 Medication Administration Procedures, dated revision 3/03, indicated PRN administration record - PRN doses shall be documented on the medication administration record, and shall have an administration summary record completed for each dose administered. The PRN administration record shall document the reason for administering the PRN medication, and shall document the observed therapeutic outcome.

LACK of SLEEP ASSESSMENT:

R39's physician orders, dated 2/23/16, included Trazodone 50 mg; give one tablet PRN for sleep at bedtime, may take one extra dose if needed.

R39's medical record lacked comprehensive sleep assessment and analysis of sleep monitoring for the use of the Trazadone.

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F 329	Continued From page 41 R39's behavior monthly flow sheets were reviewed for January 2016, February 2016 and March 2016 and revealed R39 had one episode of the behavior code for insomnia documented. On 3/3/16, at 10:15 a.m., RN-A stated a sleep assessment would be completed when a resident starts on a medication for sleep, but not with a dose change. RN-A verified R39 had a change in dose for Trazodone on 2/17/16 and the change in dose was due to R39 does not sleep well. RN-A stated she reviews behavior sheets and the nurses tell me how R39 sleeps from report. I keep a record of the information but it is not part of the resident ' s record. RN-A verified R39's record failed to include an assessment and analysis for sleep. On 3/3/16, at 11:18 a.m., the DON stated he thinks there is an assessment and an analysis of sleep was being done verbally, but evidently not documented. There was no assessment provided when requested by this surveyor. A policy and procedure was requested for comprehensive sleep assessment and was not provided. R61's admission record, dated 9/9/14, indicated the resident had diagnoses of: rheumatoid arthritis; osteoarthritis; low back pain; neuralgia and neuritis. R61's annual Minimum Data Set (MDS), dated 12/30/15, identified pain as an issue. It stated that the resident had pain within the past five days; he received as-needed pain medications; he received non-pharmacological pain relief interventions.	F 329		

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R61's physician order summary report, dated 10/30/15, indicated the physician had prescribed Tramadol HCl (a pain medication) 50 mg (milligrams): give 1 tablet by mouth every six hours as needed for pain control (take 1 tablet for pain of 4 or less. Take 2 tablets for pain of 5 or greater)(the pain scale was based on a rating of 1 to 10 with 10 being the most excruciating pain possible).

R61's care plan, dated 1/12/16, indicated the resident was at risk for pain due to rheumatoid arthritis and an indwelling catheter placement. It recommended to use medications per doctor's orders; staff were to also monitor for signs and symptoms of pain, both verbal and non-verbal.

R61's medication administration record (MAR), reviewed from 2/1/16 through 3/3/16 indicated that the resident received an as-needed dose of Tramadol a total of 8 times. The MAR did not record whether non-pharmacological pain relief interventions had been provided prior to the medication administration.

R61's treatment administration record (TAR), reviewed from 2/1/16 through 3/3/16, indicated that the resident had an order for an Aqua K-pad (heating pad)- 20 minutes three times a day for pain relief (every 8 hours as needed)- which had not been used.

R61's progress notes, reviewed from 2/1/16 through 3/3/16, did not indicate that the resident had been given non-pharmacological pain relief measures prior to the use of Tramadol.

When interviewed on 3/3/16 at 10:37 a.m.,

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registered nurse (RN)-E stated that the resident does have pain in his neck. RN-E stated that the resident received scheduled Tylenol three times a day and then he would also get as-needed Tramadol. RN-E stated that the nursing staff should be utilizing non-pharmacological pain relief measures prior to administering the as-needed Tramadol medication.

When interviewed on 3/3/16 at 10:58 a.m., the director of nursing (DON) agreed that the nursing staff should be documenting non-pharmacological pain relief measures prior to the administration of Tramadol.

Review of the document titled, "Policy and Procedure: Pain Evaluation and Management [11/26/2012]," it specified that PRN medication that was given was signed off on the PRN sheet and information which supported the use of medication and its effectiveness would also be documented.

LACK OF ANXIETY SYMPTOMS IDENTIFIED TO JUSTIFY THE USE OF AS NEEDED ATIVAN (ANTIANXIETY MEDICATION):

R61's admission record, dated 9/9/14, indicated that the resident had a diagnosis of an anxiety disorder, unspecified.

R61's order summary report, dated 12/8/15, indicated that the physician prescribed Lorazepam (an antianxiety medication). The resident was to receive 0.5 mg (milligrams) one half tablet by mouth three times a day related to anxiety.

R61's care plan, dated 1/12/16, identified the

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resident taking Lorazepam related to depression. It identified the target behaviors for the use of Lorazepam as: restlessness, anxiousness. However, the two behaviors listed lacked clear indication of resident centered behavior to determine if the ativan was affective or not.

When interviewed on 3/2/16 at 4:34 p.m., nursing assistant (NA)-H stated that R61 occasionally would have behaviors. NA-H described the resident as sometimes being aggressive. Once in a while the resident would get angry or upset. Sometimes the resident would yell or scream. Sometimes the resident would shut his door and lock himself in his room or would use verbally abusive words.

When interviewed on 3/2/16 at 4:59 p.m.,RN-F stated that sometimes the resident would get restless. RN-F described sometimes the resident would propel himself back and forth in his wheelchair and sometimes he would try to roll in to the wall. RN-F described R61's behaviors as rare.

When interviewed on 3/3/16 at 7:03 a.m.,NA-I stated that sometimes R61 would have sexual behaviors. NA-I stated that if the resident would have a behavior the nursing assistants would let the nursing staff know what happened.

When interviewed on 3/3/16 at 10:58 a.m., the director of nursing understood the need for individualized targeted behaviors to determine if the ativan was affective or not.

Review of the document titled, Psychotropic (psychoactive) drug use and documentation not dated. It specified that the prescribe identify the

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F 329	Continued From page 45 medical necessity and specific targeted behavior to be treated in the order for the psychotropic drug. It advised to list the behavior to be treated, as specified by the prescriber, in the problem list of the resident's care plan. It advised to identify the behavior being treated in the licensed nurses' progress notes. Staff should document the behavior treated and drug used. LACK OF MONITORING HEART RATE RANGE IN REGARDS TO DIGOXIN MEDICATION EFFECTIVENESS: R69's Transfer/Discharge Report included diagnoses of heart failure, hypertension (high blood pressure), and cardiomegaly (enlarged heart). R69's Medication Review Report included physician orders, signed 2/11/16, for a cardiac medication used to treat heart failure, Digoxin 125 micrograms one tablet every other day, check apical pulse (pulse taken with a stethoscope at the heart) before giving hold if apical pulse is less than 50. Review of R69's medication administration record (MAR) and electronic medical record from 12/1/15 through 3/3/16 revealed a pulse was obtained 11 out of 46 opportunities on the scheduled administration dates for Digoxin. The documentation did not include the location where the pulse was obtained or if the pulse was obtained prior to the administration of Digoxin. On 3/2/16 at 12:48 p.m. the director of nursing (DON) verified the apical pulse was not being completed prior to each administration of Digoxin, as ordered by the physician, and the pulses that were documented did not included where the pulse was taken from.	F 329		

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F 329	Continued From page 46 On 3/3/16 at 12:27 p.m. the facility pharmacist consultant stated during a phone call, "You are suppose to check the apical pulse when they [residents] gets Digoxin."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food product was disposed of. This had the potential to effect all residents in the facility. Findings include: During initial tour of the kitchen on 2/29/16, at 6:10 p.m., with prep cook (PC)-A, the walk in cooler contained a plastic storage container of sliced ham with an open date of 2/17/16. On 3/02/16, at 10:48 a.m., the dietary director (DD)-D stated the facility policy was for a staff person to go through the food coolers every Wednesday and dispose of any outdated food product. The DD-D stated food product is usually disposed of seven days after the date opened.	F 371	It is policy of this facility that dietary staff will not keep leftovers of any amount under fifty servings. Policy also states that facility will dispose of any outdated food product and will document food disposal weekly. Food product disposed of seven days after the date opened. Dietary team failed to dispose of sliced ham timely, ham was disposed of on 2/29/16. Because all residents□ food is potentially affected by the cited deficiency on 3/3/2016, the Dietary director reviewed the policy and responsibilities with the dietary staff immediately on 3/3/16. To enhance currently compliant operations and under the direction of the director of dietary, staff received in-service training regarding state and federal requirements	4/1/16

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F 371	Continued From page 47 The DD-D stated the ham dated 2/17/16, should have been disposed of. The facility policy Use of left over foods, dated 4/30/15, indicated Lakeview's food service department will not keep leftovers of any amount under fifty servings.	F 371	for food disposal. The training emphasized the importance of proper food storage and disposal as indicated in the policy and procedure. Effective 3/3/16, the QA committee will monitor. The director of dietary or designated quality-assurance representative will perform monitoring dates on all food to assure compliance. The Director of Dietary has developed an audit tool and put in place for weekly sign off, and the findings of the quality assurance audits will be documented and submitted at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the	F 428	It is policy of this facility that nursing staff	4/1/16

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F 428	Continued From page 48 facility failed to ensure the consultant pharmacist indented the lack of non-pharmacological interventions for as needed medications for 3 of 5 residents (R8, R39 & R61) reviewed for unnecessary medications, identify individualized mood symptoms for the use of Ativan for 1 of 5 residents (R61) reviewed for unnecessary medications, and the consultant pharmacist failed to identify an apical pulse was obtained, as ordered by the physician, prior to administration of a cardiac medication for 1 of 5 residents (R69) reviewed for unnecessary medications. Findings Include: LACK OF NON-PHARMACOLOGICAL INTERVENTIONS AND IF AFFECTIVE TO RELIEVE PAIN AND ANXIETY: R8 was admitted to the facility on 12/6/2010 with diagnoses including: backache unspecified, abdominal pain unspecified and depressive disorder per the face sheet. R8's current physician orders dated included as needed (PRN) orders for the following psychotropic and pain medications: "Ativan Tablet 0.5 MG [milligrams] (Lorazepam); Give 1 tablet by mouth every 6 hours needed for anxiety related to Anxiety Disorder Unspecified; see non-medicated prevention sheet before giving the med [medication]." "Acetaminophen Tablet; Give 650 MG by mouth every 4 hours as needed for elevated temp (101-102 F), headache or minor discomfort, may also be given by rectal suppository."	F 428	will document non-pharmacological interventions for psychotropic and pain medications. Resident R8 was receiving Ativan, Oxycodone, Tylenol, and Trazadone as PRN medications. With the electronic medication administration system we were able to place hard stops within the system to make sure non-pharmacological interventions were completed and documented for all of these medications. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to non-pharmacological interventions. R 8□s care plan was updated for non-pharmacological sleep, pain and psychotropic interventions specific to the resident. Due to resident being on Trazadone a sleep study was initiated on 3/4/16. Resident R 39 is receiving Seroquel, Tylenol, Gabapentin. With the electronic medication administration system we were able to place hard stops within the system to make sure non-pharmacological interventions were completed and documented for all of these medications. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to non-pharmacological interventions. R 39□s care plan was updated for non-pharmacological sleep, pain and psychotropic interventions specific to the resident. Due to resident being on Trazadone a sleep study was initiated on 3/4/16.	

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F 428	Continued From page 49 Review of the March 2016 medication administration record showed the following: R8 received PRN Ativan four times from 3/1/16 to 3/3/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R8 received PRN acetaminophen three times from 3/1/16 to 3/3/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered. Review of the February 2016 medication administration record showed the following: R8 received PRN Ativan sixteen times from 2/1/16 to 2/29/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R8 received PRN acetaminophen thirteen times from 2/1/16 to 2/29/16 with no documentation of reason to give the medication and no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered. Review of the January 2016 medication administration record showed the following: R8 received PRN Ativan forty-one times from 1/1/16 to 1/31/16 with no documentation of reason to give the medication and no	F 428	R 61 is receiving Tramadol and Ativan. With the electronic medication administration system we were able to place hard stops within the system to make sure non-pharmacological interventions were completed and documented for all of these medications. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to non-pharmacological interventions. R 61□s care plan was updated for non-pharmacological pain and psychotropic interventions specific to the resident. R 61□s primary physician Dr. Green was contacted and he provided documentation to justify use of PRN Ativan. R 69 is receiving Digoxin every other day. At time of survey no documentation of pulse was recorded consistently with the medication administration. With the electronic medication administration system we were able to place hard stops within the system to make sure pulse is documented each time medication is given. Resident Care Coordinator and licensed nursing staff were educated on 3/4/16 regarding state and federal regulations related to medication administration and supplemental documentation. Going forward all residents receiving PRN pain, psychotropic and sleep medications will have non-pharmacological intervention documentation built into the resident□s MAR. Sleep medications will require a sleep study for all residents. Any resident on Digoxin will have pulse	

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F 428	Continued From page 50 documentation of non-pharmacological interventions attempted prior to the PRN Ativan being administered. R8 received PRN acetaminophen twelve times from 1/1/16 to 1/31/16 with no documentation of reason to give the medication (no pain scale used) and no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered. R8's care plan included non-medical interventions for use for PRN Ativan however there was no indication they were used before giving medication as follows: 1. Offers reassurance 2. Listen and allow res to vent 3. Assess pain 4. Assess bowel issues 5. Offer food and fluids R8's care plan also indicated R8 was often uncooperative with non-medicated interventions, will tell staff, "don't ask me that again, just give me my pills", "I just want my pills." However, there was no indication that the current care plan interventions were affective or a reassessment of pain to determine new interventions for treating pain. On 3/03/2016, at 10:52 a.m. the director of nursing (DON) stated staff should attempt non-pharmacological intervention for the use the PRN medication whenever possible, staff should document the reason the medication was being given and if the medication was effective. On 3/03/2016, at 11:34 p.m. the DON stated the	F 428	monitored and documented with administration. To enhance currently compliant operations and under the direction of the director of nurses, all nursing staff will receive in-service training regarding state and federal requirements medication administration and supplemental documentation. Effective 3/4/16 the Interdisciplinary Team will track implementation under supervision of the Director of Nursing to track consultant pharmacist drug reviews to ensure the cited deficiencies are addressed. The IDT will perform the following systematic changes: checking monthly drug reviews as completed by consultant pharmacist to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	

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F 428	Continued From page 51 facility started documenting behaviors and PRN medication administration in point click care starting in January 2016. The DON told writer I would not find any documentation of non-pharmacological interventions being documented in the medical record since the system was changed to point click care. On 3/03/2016, at 11:55 a.m. licensed practical nurse (LPN)-A stated she attempted non-pharmacological interventions, would document the reason the medication was being given and stated she would go back after a half an hour to check to see if the medication worked when she administered PRN medications. LPN-A stated she documented the non- pharmacological interventions attempted prior to administration of the medication in the nurse notes, "although I do know my residents pretty well. There are some of them you know you can offer non-pharmacological interventions and you know they just won't accept them. LPN-A stated you can suggest to R8 to go to the bathroom, try to eat something, and R8 will continuously put the call light on and ask for her scheduled oxycodone, her prn Tylenol and prn Ativan." On 03/03/2016, at 1:11 p.m. registered nurse (RN)-A stated with the new computer system there was not a place to document the non-pharmacological intervention attempted prior to administration of the PRN Ativan, however stated the nurses should then document in the progress notes. RN-A stated the previous system used prompted staff to document non-pharmacological interventions attempted and the reason medication was given. RN-A confirmed the facility staff were not following the care plan to offer non-pharmacological	F 428		

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interventions as R8 would consistently refuse them, become very upset and accusatory towards staff when attempted.

The Psychotropic (Psychoactive) Drug Use and Documentation procedure dated 12/29/13 instructed staff, "...Psychoactive drugs are used only in the resident's best interest, never for the convenience of staff or as punishment. Non-drug approaches and interventions and/or drug therapy are used whenever possible." The procedure instructed staff to...8. If psychotropic drugs are administered on a prn [as needed] basis, document on the back of the medication form the drug and the amount given, the targeted behavior, and the effectiveness of the drug. If necessary, document more specifically in the nurses' notes..."

The Pain Evaluation and management policy dated 11/26/2012 instructed staff to, "...4. PRN medication that is given will be signed off on the PRN sheet and information supporting the use of the medication and its effectiveness will also be documented..."

LACK OF COMPREHENSIVE SLEEP ASSESSMENT AND ANALYSIS TO JUSTIFY THE USE OF A SLEEP MEDICATION:

R8's admission record revealed R8 was admitted on 2/6/2010 with diagnoses of depressive disorder. The quarterly Minnesota Data Assessment (MDS) dated 12-9-15, indicated R11 did not display behavior problems and did have difficulty sleeping, feeling tired or having little energy.

R8's signed physician orders dated 1/14/16

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F 428	Continued From page 53 included Trazodone 50 milligrams (mg) by mouth daily for insomnia. R8's care plan did not include non-pharmacological interventions for sleep. R8's behavior monthly flow sheets were reviewed for January 2016, February 2016 and March 2016 and revealed R8 had no documented concerns with insomnia. On 3/02/2016 3:29 p.m. registered nurse (RN)-A stated tracking the sleep pattern on the behavior sheets was the sleep assessment completed by the facility. RN-A stated the facility completed sleep evaluations upon admission, upon start of a medication or if the pharmacist requested a sleep evaluation. RN-A stated she reviewed sleep on a quarterly basis based on the documentation of the behavior monthly flowsheets and also listened to the overnight report every day. RN-A stated there were not any non-pharmacological interventions developed as a part of R8's care plan for sleep as the Trazodone was scheduled to be given daily. On 03/03/2016, at 9:56 a.m. registered nurse (RN)-A stated staff track R8's insomnia of the behavior tracking sheets. RN-A confirmed the behavior monthly flow sheets provided for January 2016, February 2016 and March 2016 revealed R8 had no documented concerns with insomnia. RN-A stated staff just know her (R8) and her sleep patterns. RN-A stated another nurse in the facility had completed two comprehensive sleep assessments for R8, however unable to provide to surveyor for review. A policy and procedure was requested for	F 428		

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F 428	Continued From page 54 comprehensive sleep assessment and was not provided R39's Admission record dated 3/3/16, identified diagnoses of low back pain, delusional disorders, major depressive disorder, psychotic disorder with hallucinations due to known psychological condition, anxiety, dementia, and personality disorder. R39's quarterly MDS dated 1/20/16, indicated R39 had verbal behaviors, received scheduled and as needed (PRN) pain medications, received no non-pharmacological interventions for pain, received antipsychotic and antidepressant medications. R39's current physician orders dated 2/23/16, included PRN orders for the following psychotropic and pain medications: Seroquel 50 mg, one tablet as needed (PRN) for behaviors/delusions related to delusional disorders, major depressive disorder, psychotic disorder with hallucinations due to known physiological condition. Acetaminophen (Tylenol) 650 mg every four hours PRN for elevated temp (101-102 F), headache or minor discomfort, may also be given by rectal suppository. Tylenol 1000 mg every eight hours PRN for pain. Gabapentin (an anti-seizure drug used to treat pain) solution 250 mg/5 ml (milliliters), give 2.5 ml every two hours PRN for anxiety/pain (may give up to three times per day). Review of the March 2016 medication administration record (MAR) and progress notes showed the following:	F 428		

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F 428	Continued From page 55 R39 had received Seroquel PRN one time on 3/1/16, with no documentation of non-pharmacological interventions attempted prior to the PRN Seroquel being administered. R39 had received Tylenol (acetaminophen) PRN three times from 3/1/16 to 3/2/16 with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered for 3 of 3 doses. R39 had received Gabapentin one time on 3/2/16 with no documentation of non-pharmacological interventions attempted prior to the PRN Gabapentin being administered. Review of the February 2016 MAR and progress notes showed the following: R39 had received Seroquel PRN 10 times, with no documentation of the reason to give the medication for four out of 10 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN Seroquel being administered for 10 out of 10 doses. R39 had received Tylenol (acetaminophen) PRN 15 times, with no documentation of the reason to give the medication for nine out of 15 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered for 15 out of 15 doses. R39 had received Gabapentin seven times, with	F 428		

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no documentation of the reason to give the medication for three out of seven doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN Gabapentin being administered for seven out of seven doses.

Review of the January 2016 MAR and progress notes showed the following:

R39 had received Seroquel PRN 14 times, with no documentation of the reason to give the medication for four out of 14 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN Seroquel being administered for 14 out of 14 doses.

R39 had received Tylenol (acetaminophen) PRN 17 times, with no documentation of the reason to give the medication for seven out of 17 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN acetaminophen being administered for 17 out of 17 doses.

R39 had received Gabapentin 10 times, with no documentation of the reason to give the medication for three out of 10 doses administered and with no documentation of non-pharmacological interventions attempted prior to the PRN Gabapentin being administered for 10 out of 10 doses.

R39's care plan included non-medical interventions for use for PRN psychotropic medications as follows:
1. Assess pain
2. Offer reassurance, listen to concerns

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F 428	Continued From page 57 3. Toilet resident 4. Reorient as needed 5. Provide for resident safety 6. Take resident to activity, 1-1 if possible 7. Assess food and fluid needs 8. Ease anxiety by bringing resident to ice machine R39's care plan failed to address pain management including non-medication interventions to be attempted first before giving pain medication to control pain. On 3/3/16, at 10:15 a.m., RN-A verified chronic pain was not addressed on R39's care plan. RN-A verified reasons for giving and non-pharmalogical interventions prior to administration of PRN psychotropic medications and PRN pain medications was not being documented. RN-A stated she would absolutely expect non-pharmalogical interventions to be offered as per the plan of care. On 3/3/16, at 11:18 a.m., the DON stated the goal is to offer non-pharmacological measures before giving a PRN medication. I think the breakdown is when we went to point click care (computer program), then the offer of non-pharmalogical measures stopped being done. I would expect the reason the medication was being given to be documented. The facility Pharmaceutical Services Policy and Procedure Manual 5.30 Medication Administration Procedures, dated revision 3/03, indicated PRN administration record - PRN doses shall be documented on the medication administration record, and shall have an administration summary record completed for each dose	F 428		

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F 428	Continued From page 58 administered. The PRN administration record shall document the reason for administering the PRN medication, and shall document the observed therapeutic outcome. LACK of SLEEP ASSESSMENT: R39's physician orders, dated 2/23/16, included Trazodone 50 mg; give one tablet PRN for sleep at bedtime, may take one extra dose if needed. R39's medical record lacked comprehensive sleep assessment and analysis of sleep monitoring for the use of the Trazadone. R39's behavior monthly flow sheets were reviewed for January 2016, February 2016 and March 2016 and revealed R39 had one episode of the behavior code for insomnia documented. On 3/3/16, at 10:15 a.m., RN-A stated a sleep assessment would be completed when a resident starts on a medication for sleep, but not with a dose change. RN-A verified R39 had a change in dose for Trazodone on 2/17/16 and the change in dose was due to R39 does not sleep well. RN-A stated she reviews behavior sheets and the nurses tell me how R39 sleeps from report. I keep a record of the information but it is not part of the resident ' s record. RN-A verified R39's record failed to include an assessment and analysis for sleep. On 3/3/16, at 11:18 a.m., the DON stated he thinks there is an assessment and an analysis of sleep was being done verbally, but evidently not documented. There was no assessment provided when requested by this surveyor.	F 428		

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F 428	Continued From page 59 A policy and procedure was requested for comprehensive sleep assessment and was not provided. R61's admission record, dated 9/9/14, indicated the resident had diagnoses of: rheumatoid arthritis; osteoarthritis; low back pain; neuralgia and neuritis. R61's annual Minimum Data Set (MDS), dated 12/30/15, identified pain as an issue. It stated that the resident had pain within the past five days; he received as-needed pain medications; he received non-pharmacological pain relief interventions. R61's physician order summary report, dated 10/30/15, indicated the physician had prescribed Tramadol HCl (a pain medication) 50 mg (milligrams): give 1 tablet by mouth every six hours as needed for pain control (take 1 tablet for pain of 4 or less. Take 2 tablets for pain of 5 or greater)(the pain scale was based on a rating of 1 to 10 with 10 being the most excruciating pain possible). R61's care plan, dated 1/12/16, indicated the resident was at risk for pain due to rheumatoid arthritis and an indwelling catheter placement. It recommended to use medications per doctor's orders; staff were to also monitor for signs and symptoms of pain, both verbal and non-verbal. R61's medication administration record (MAR), reviewed from 2/1/16 through 3/3/16 indicated that the resident received an as-needed dose of Tramadol a total of 8 times. The MAR did not record whether non-pharmacological pain relief interventions had been provided prior to the medication administration.	F 428		

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R61's treatment administration record (TAR), reviewed from 2/1/16 through 3/3/16, indicated that the resident had an order for an Aqua K-pad (heating pad)- 20 minutes three times a day for pain relief (every 8 hours as needed)- which had not been used.

R61's progress notes, reviewed from 2/1/16 through 3/3/16, did not indicate that the resident had been given non-pharmacological pain relief measures prior to the use of Tramadol.

When interviewed on 3/3/16 at 10:37 a.m., registered nurse (RN)-E stated that the resident does have pain in his neck. RN-E stated that the resident received scheduled Tylenol three times a day and then he would also get as-needed Tramadol. RN-E stated that the nursing staff should be utilizing non-pharmacological pain relief measures prior to administering the as-needed Tramadol medication.

When interviewed on 3/3/16 at 10:58 a.m., the director of nursing (DON) agreed that the nursing staff should be documenting non-pharmacological pain relief measures prior to the administration of Tramadol.

Review of the document titled, "Policy and Procedure: Pain Evaluation and Management [11/26/2012]," it specified that PRN medication that was given was signed off on the PRN sheet and information which supported the use of medication and its effectiveness would also be documented.

LACK OF ANXIETY SYMPTOMS IDENTIFIED TO JUSTIFY THE USE OF AS NEEDED ATIVAN

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	245280	A. BUILDING _____ B. WING _____	03/03/2016

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F 428	Continued From page 61 (ANTIANXIETY MEDICATION): R61's admission record, dated 9/9/14, indicated that the resident had a diagnosis of an anxiety disorder, unspecified. R61's order summary report, dated 12/8/15, indicated that the physician prescribed Lorazepam (an antianxiety medication). The resident was to receive 0.5 mg (milligrams) one half tablet by mouth three times a day related to anxiety. R61's care plan, dated 1/12/16, identified the resident taking Lorazepam related to depression. It identified the target behaviors for the use of Lorazepam as: restlessness, anxiousness. However, the two behaviors listed lacked clear indication of resident centered behavior to determine if the ativan was affective or not. When interviewed on 3/2/16 at 4:34 p.m., nursing assistant (NA)-H stated that R61 occasionally would have behaviors. NA-H described the resident as sometimes being aggressive. Once in a while the resident would get angry or upset. Sometimes the resident would yell or scream. Sometimes the resident would shut his door and lock himself in his room or would use verbally abusive words. When interviewed on 3/2/16 at 4:59 p.m.,RN-F stated that sometimes the resident would get restless. RN-F described sometimes the resident would propel himself back and forth in his wheelchair and sometimes he would try to roll in to the wall. RN-F described R61's behaviors as rare.	F 428		

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F 428	Continued From page 62 When interviewed on 3/3/16 at 7:03 a.m.,NA-I stated that sometimes R61 would have sexual behaviors. NA-I stated that if the resident would have a behavior the nursing assistants would let the nursing staff know what happened. When interviewed on 3/3/16 at 10:58 a.m., the director of nursing understood the need for individualized targeted behaviors to determine if the ativan was affective or not. Review of the document titled, Psychotropic (psychoactive) drug use and documentation not dated. It specified that the prescribe identify the medical necessity and specific targeted behavior to be treated in the order for the psychotropic drug. It advised to list the behavior to be treated, as specified by the prescriber, in the problem list of the resident's care plan. It advised to identify the behavior being treated in the licensed nurses' progress notes. Staff should document the behavior treated and drug used. LACK OF MONITORING HEART RATE RANGE IN REGARDS TO DIGOXIN MEDICATION EFFECTIVENESS: R69's Transfer/Discharge Report included diagnoses of heart failure, hypertension (high blood pressure), and cardiomegaly (enlarged heart). R69's Medication Review Report included physician orders, signed 2/11/16, for a cardiac medication used to treat heart failure, Digoxin 125 micrograms one tablet every other day, check apical pulse (pulse taken with a stethoscope at the heart) before giving hold if apical pulse is less than 50. Review of R69's medication administration record (MAR) and electronic medical record from	F 428		

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F 428	Continued From page 63 12/1/15 through 3/3/16 revealed a pulse was obtained 11 out of 46 opportunities on the scheduled administration dates for Digoxin. The documentation did not include the location where the pulse was obtained or if the pulse was obtained prior to the administration of Digoxin. On 3/2/16 at 12:48 p.m. the director of nursing (DON) verified the apical pulse was not being completed prior to each administration of Digoxin, as ordered by the physician, and the pulses that were documented did not included where the pulse was taken from. On 3/3/16 at 12:27 p.m. the facility pharmacist consultant stated during a phone call, "You are suppose to check the apical pulse when they [residents] gets Digoxin."	F 428		
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. In accordance with State and Federal laws, the	F 431		4/1/16

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F 431	Continued From page 64 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 that expired medications were removed from a random medication storage review which included R65 and R15 and the facility failed to ensure the medication label matched the physician order for 1 of 6 residents (R27) observed during the medication pass. Findings include: During an observation of the third floor South wing medication cart with licensed practical nurse (LPN)-F on 2/29/16 at 6:44 p.m., there was a bottle of expired Meclizine medication (used to prevent nausea and vomiting) that had an expiration date of 1/2016 for R65. There were four tablets remaining in the bottle. When asked about the expired medication, LPN-F stated the medication had expired.	F 431	It is policy of this facility to ensure that no expired medications are administered. R 65 and R 15□s expired medications were removed immediately and re-ordered. Expired stock medication was also removed, disposed of and replaced. R27 was found to have the wrong label on her discus inhaler at time of survey. Medication order change warning label was added. Staff educated on 3/4/16 of proper re-labeling process of adding medication order change warning label to the medication and to notify pharmacy of order change for all residents. On 3/4/2016 staff educated on proper medication administration on all residents. To enhance currently compliant operations and under the direction of the director of nurses, all nursing staff will receive in-service training regarding state	

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F 431	Continued From page 65 During the same observation of the third floor south hall medication cart with LPN-F on 2/29/16 at 6:48 p.m.,Advair Discus inhalant medication had an expiration date of 2/26/16 on it. LPN-F stated that the medication had expired. This inhaler was R15's only inhaler in the medication cart. R15's order summary report, dated 10/18/15, indicated that the resident had a physician's order for Advair Diskus Aerosol Powder Breath Activated 250-50 mcg (micrograms)/dose: 1 puff inhalation two times a day related to chronic obstructive pulmonary disease. When interviewed on 2/29/16 at 6:55 p.m., licensed practical nurse (LPN)-F stated that the nursing staff would usually check for expired medications every Tuesday when all the medication carts were checked to see if anything needed to be stocked or reordered. LPN-F stated that the day-shift nursing staff would check the carts every Tuesday as well as Sunday for expired medications. During an observation of the third floor west medication cart on 2/29/16 at 7:30 p.m. with licensed practical nurse (LPN)-F, there were two bottle of stock medications (medications which could potentially be used by any resident in the facility if so prescribed) that were expired. One bottle of aspirin, 325 mg tablets, had expired in 2/2015. A second bottle of aspirin, 325 mg, had expired in 4/2015. LPN-F stated that the medications had expired. During an observation of the second floor south hall medication cart with licensed practical nurse	F 431	and federal requirements for minimizing medication administration errors. Effective 3/4/16 the quality-assurance program will track implementation under supervision of the Director of Nursing for medication administration. The director of nursing or designated quality-assurance representative will perform the following systematic changes: checking all resident□s medications for expiration dates and accurate medication labels to assure continued compliance. The findings of the quality-assurance checks will be addressed at the quarterly quality-assurance committee meeting for further review. This monitoring will continue until it goes through the QA&A board for review and acceptance. All staff will be educated on this revised policy by 4/1/2016 by Director of Nursing.	

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F 431	Continued From page 66 (LPN)-G on 2/29/16 at 7:53 p.m., there was one bottle of stock medication of aspirin. It had a strength of 325 mg. It had an expiration date of 4/2015. LPN-G could not state for sure whether this particular medication had been given or not. LPN-G did not know who checked the medication carts for expiration dates or how often this was done. During an observation of the second floor west medication cart with licensed practical nurse (LPN)-H on 2/29/16 at 8:10 p.m., R27's Advair Diskus inhaler had an expiration date of 1/4/16. LPN-H stated that there were twelve remaining doses of medication in the inhaler. LPN-H stated that the resident received two puffs from the inhaler twice daily. LPN-H said, "We are supposed to date the box when we open it." R27's order summary report, dated 11/9/15, indicated that R27 had been prescribed Advair Diskus Aerosol Powder Breath Activated 250-50 mcg (micrograms)/dose and was to take 1 puff inhalation two times a day related to chronic obstructive pulmonary disease. When interviewed on 3/3/16 at 8:39 a.m., the director of nursing stated that the nursing staff should have checked for expired medications and removed them from use. Review of the document titled, Policy and Procedure: Medication Storage no date, specified that outdated medications were to be immediately removed from the stock and disposed of according to the facility procedures for medication destruction. Those medications were to be then reordered from the pharmacy if a current order existed.	F 431		

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F 431	Continued From page 67 Review of the document titled, "Policy and Procedure: Medication Administration [no date]," it specified that dates would be placed on a medication container to monitor for expiration dates if applicable. It advised that expiration dates would be reviewed prior to administration of a medication. R27 was observed during an medication administration pass on 3/3/16 at 8:08 a.m., Registered nurse (RN)-G gave R27 the Advair Diskus inhaler to self administer her own medication. The label on the Advair Diskus inhaler read, "Advair Diskus 250/50 inhale 2 puffs twice daily." R27 was observed to only take one inhalation of the Advair Diskus. R27 stated that she only does one puff of the Advair Diskus twice daily. When asked if there had been a medication error, RN-G stated that she was not sure as that had been the way the resident had always taken her medication. RN-G stated that she would fax the doctor. When interviewed on 3/3/16 at 11:51 a.m., registered nurse (RN)-G stated that R27's Advair Diskus bottle was labeled incorrectly. She stated that R27 received the correct dosage of the medication. She stated that the physician had ordered for R27 to receive the Advair 1 puff twice daily. R27 confirmed that this was correct. RN-G stated that when an order was changed by the physician, a sticker should be affixed on the bottle to alert the staff that there had been a dosage change. RN-G stated that she had put a sticker on R27's Advair inhaler to alert the staff that there was a dosage change. Review of the document titled, Policy and	F 431		

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F 431	Continued From page 68 Procedure: Medication Labels no date, specified that any new medication change orders which resulted in new directions on the container label should necessitate a new label. It advised that a new label would be prepared and affixed to the medication container at the time of the next refill. The nurse would remove the respective container of medication and cross the existing label with a large black line or "X." The nurse would then administer medications from the medication sheet record. After the nurse received an updated medication label at the date of the next refill or delivery, the nurse would ensure the directions were correctly typed on the new label.	F 431		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		4/1/16

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F 520	Continued From page 69 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical director, or designated physician, attended quality assessment and assurance (QAA) meetings for 3 of 4 quarterly QAA meetings. Findings include: Review of the facility's QAA meeting attendance record reviewed from 4-30-15 to 1-20-16 revealed the medical director attended the QAA meeting held on 7-22-15 only. The attendance record revealed no physician attended the QAA meetings held on 4-30-15, 10-21-15, and 1-10-16. On 3/2/16 at 4:04 p.m. the administrator stated, "[the medical director] hasn't been here for quite a while for our meetings. We schedule around his schedule and then he won't be able to attend." The administrator added on 3/3/16 at 11:54 a.m. "Sometimes he [the medical director] just doesn't come. We encourage him to come and if he calls soon enough we can change the date. We don't know when he doesn't come until the meeting happens and he isn't here." A facility policy on QAA was requested but not provided.	F 520	Facility found to not ensure medical director, or a designee attended all quarterly QAA meetings. On 3/4/16 Director of Nursing educated Medical Director about attendance at QAA meetings. Medical Director has appointed a designee to attend in his absence. Facility administrator will monitor that medical director or designee is in attendance for QAA meetings.	

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	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/02/2016**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS 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, on March 2, 2016. At the time of this survey, Building 01 of Lakeview Methodist Health Care Center was NOT found not to be 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 Occupancies. Lakeview Methodist Health Care Center was constructed as follows: Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story	K 000	EPOC	

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

Electronically Signed | 03/25/2016

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 in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. 2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies. In accordance with NFPA 101 (2000) Chapter 19, Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 60 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		4/1/16

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K 025	Continued From page 2 This STANDARD is not met as evidenced by: K25: Based on observations and interview, the facility has failed to properly construct and maintain a required 2-hour fire separation, in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. In a fire emergency, this deficient practice could adversely affect the safety of 3 patients, staff and visitors. FINDINGS INCLUDE: During the facility tour between the hours of 12:30 AM and 4:00 PM on 3/02/2016, observation revealed: The smoke barrier separation on the 2nd floor (24N) and 3rd floor (320) has penetrations above the lay-in ceiling. This deficient practice was verified by the Maintenance Supervisor.	K 025	Penetrations on 2nd floor (24N) and 3rd floor (320) above the lay-in ceiling were filled on 3/17/2016 with approved smoke and fire barrier materials. All other smoke and fire barriers have been inspected for penetrations. Director of building services responsible for monitoring and compliance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		4/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(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
K 056	Continued From page 3 This STANDARD is not met as evidenced by: If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 K56:Based on observations and interview, a fire sprinkler head in custodian room 2nd floor has been found to have paint on the head.	K 056	Sprinkler head in 2nd custodian room was replaced 3/21/2016. Director of building services responsible for monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**03/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(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
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 2,2016. At the time of this survey, Building 02 of Lakeview Methodist Health Care Center was found to be 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 Occupancies.

Lakeview Methodist Health Care Center was constructed as follows:
Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction;
Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction.

2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies.

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/25/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**03/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(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
K 000	Continued From page 1 In accordance with NFPA 101 (2000) Chapter 19, Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 60 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET	K 000		