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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: D0D7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00758

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245304**
2.STATE VENDOR OR MEDICAID NO.
(L2) **847972200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANGELS CARE CENTER**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

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) **12/20/2013**

6. DATE OF SURVEY **02/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **74** (L18)

13.Total Certified Beds **74** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Josephine Hassinger, HFE NE II 02/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/28/2015
(L33)

DETERMINATION APPROVAL

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

CCN 24-5304

On February 5, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on November 12, 2014 and the standard survey completed on December 12, 2014. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on November 12, 2014 and the standard survey completed on December 12, 2014, as of February 4, 2015. Please refer to the 2567b.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245304

March 26, 2015

Ms. Kristina Umberger, Administrator
Angels Care Center
300 North Dow Street
Cannon Falls, Minnesota 55009

Dear Ms. Umberger:

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

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

Effective January 21, 2015 the above facility is certified for or recommended for:

74 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 74 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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245304	A. Building B. Wing	2/5/2015

Name of Facility	Street Address, City, State, Zip Code
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **01/21/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **01/21/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **01/21/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **01/21/2015**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **01/21/2015**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0361** Reg. # **483.35(a)** LSC	Correction Completed **01/21/2015**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **01/21/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	02/20/2015	33559	02/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245304	A. Building B. Wing	2/5/2015

Name of Facility	Street Address, City, State, Zip Code
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/21/2015**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	02/20/2015	33559	02/05/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 12/12/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245304	A. Building B. Wing 01 - MAIN BUILDING 01	1/22/2015

Name of Facility	Street Address, City, State, Zip Code
ANGELS CARE CENTER	300 NORTH DOW STREET CANNON FALLS, MN 55009

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 01/21/2015	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 01/21/2015	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 01/21/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/kfd	Date: 02/20/2015	Signature of Surveyor: 25822	Date: 01/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 12/12/2014		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: D0D7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00758

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245304**

2.STATE VENDOR OR MEDICAID NO.
(L2) **847972200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ANGELS CARE CENTER**
(L4) **300 NORTH DOW STREET**
(L5) **CANNON FALLS, MN** (L6) **55009**

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) **12/20/2013**

6. DATE OF SURVEY **12/12/2014** (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 **74** (L18)

13.Total Certified Beds **74** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(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 :
Robyn Woolley, HFE NE II 01/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: January 2, 2015

Ms. Kristina Umberger, Administrator
Angels Care Center
300 North Dow Street
Cannon Falls, Minnesota 55009

RE: Project Number S5304024, H5304022

Dear Ms. Umberger:

On November 12, 2014, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints (OHFC) to investigate the following complaints H5304023, H5304024, H5304025, H5304026 and H5304027 and to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby significant corrections are required.

On December 12, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the December 12, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5304022, that was found to be substantiated. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E) , as evidenced by the attached CMS-2567, whereby corrections are required.

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

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

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

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

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

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

In our letter to you dated November 25, 2014 we notified you of the following remedy, which remains in effect:

- State Monitoring effective November 30, 2014.

In addition, our November 25, 2014 notice informed you that the following remedy was recommended to the CMS Region V Office for imposition:

- Per instance civil money penalty for the deficiency cited at F330 (42 CFR 488.430 through 488.444)

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

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

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 12, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 12, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 12, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Angels Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective February 12, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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
Minnesota Department of Health
18 Wood Lake Drive Southeast

Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 February 12, 2015 (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 May 12, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
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
	245304	A. BUILDING _____ B. WING _____	12/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS CARE CENTER	**300 NORTH DOW STREET CANNON FALLS, MN 55009**

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint H5304022 was completed. The complaint was substantiated. Deficiencies issued at F272, F325, F361.	F 000		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to act on grievances of cold food, call light wait times and staffing	F 244	Facility policy and procedure on Resident Council was reviewed and updated. Issues regarding food, call lights and	1/21/15

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

Electronically Signed | 01/09/2015

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

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F 244	Continued From page 1 concerns expressed during resident council meetings. Eleven of 23 residents interviewed (R55, R27, R62, R42, R9, R61, R73, R98, R36, R45, R32) expressed concerns regarding food, call light and staffing concerns. Findings include: Review of the September 24, 2014 resident council meeting minutes, attended by 8 unnamed residents, indicated residents expressed concerns about cold food. In addition, the minutes of the meeting indicated the facility was working to make sure that the nursing aides were not turning off the residents' call lights before actually helping the resident. One resident expressed concerned about the number of staff to care for residents. The director of nursing (DON) responded by stating she just had a meeting with nursing staff to discuss concerns and planned to have regular quarterly meetings. DON also indicated the facility did have trouble hiring adequate staff but was getting back on track. The October 22, 2014 resident council meeting minutes, attended by 10 unnamed residents, indicated the dietary department was trying to use insulated basins and covers on room trays to keep food warmer. Unnamed residents complained of having extended wait times for call lights to be answered. An unnamed staff member responded the facility was working on hiring additional staff. The November 26, 2014 resident council meeting minutes, attended by 9 unnamed residents, indicated call lights were not being answered, staff were turning off call lights without helping the residents, and the facility was understaffed. No	F 244	staffing were reviewed in Resident Council on December 24th, 2014. Process for resident council is for each department to review past concerns then address new business. Resident council meeting are held monthly. All department heads were educated on updated Resident Council Policy and Procedure. TR Director will audit minutes to ensure concerns/grievances have been addressed. Audits will be completed for three months and reported to QA to ensure compliance.	

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resolutions were given for the residents continued complaints.

Resident interviews revealed the following:

When interviewed on 12/8/14, at 1:00 p.m. R55 had a meal tray in the room and stated, "The food is always cold."

When interviewed on 12/8/14, at 4:14 p.m. R27 reported the food was not hot enough. Staff had been informed of the concern on several occasions. R27 expressed the feeling of "just accepting the situation." R27 preferred not to send the food back for reheating because it took longer to get the food back.

During an interview with R62 on 12/8/14, at 5:07 p.m. the concern about food being cold was addressed. R62 received a room tray for all three meals and expressed frustration because the majority of the time the food was cold, especially the eggs every morning. During observation, the breakfast tray was delivered on 12/10/14 at 8:11 a.m. R62 stated the eggs were still cold and expressed frustration that it happened all the time. R62 expressed concern about the staffing due to having to wait for longer than every two hours for repositioning with a Stage 4 healing pressure ulcer on the coccyx. (Stage IV Pressure Ulcer - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.)

R42, interviewed on 12/8/14 at 6:39 p.m., indicated she put the call light on and staff sometimes did not respond to help her. R42 was unsure how long she usually waited for her call

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F 244	Continued From page 3 lights to be answered. On 12/8/14 at 5:40 p.m. R9 revealed the food was not always hot and added he just, "eats it anyway." R9 indicated sometimes he waited a half hour for help after he put his call light on. R9 indicated he had accidents waiting for staff to come, which made him feel, "pretty down hearted." On 12/8/14 at 7:12 p.m., R61 reported, if she ate in her room, the food was cold. R61 reported she waited for help after turning her call light on for approximately a half hour. R61 revealed she had wet herself, which made her feel horrible. On 12/8/14 at 4:47 p.m., R73 indicated she had wet the bed two times waiting for help. R73 reported she waited sometimes for 1-1/2 hours for help. R73 reported she waited a particularly long time the previous weekend and most day shifts. During interview on 12/09/2014, at 10:07 a.m. R98 reported the food served at the facility was often cold. During interview on 12/09/2014, at 1:39 p.m. R36 reported the food served at the facility was often cold, especially eggs at breakfast. R36 explained the facility staff would re-warm the food if requested, but he often just ate the cold food because he was hungry and did not want to wait. R45 was interviewed on 12/10/14, at 8:46 a.m. and talked about being in the restaurant business for many years and knew how important it was to keep food hot and between certain temperatures. R45 reported the facility was aware of the cold	F 244		

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food situation, but had not taken care of the cold food issues yet.

On 12/12/2014, at 9:40 a.m. an active council member (R32) was asked about call lights and cold food being addressed in the resident council meetings. R32 confirmed residents at resident council meetings had expressed concerns about call light wait times. R32 reported long call light wait times were a concern for him. R32 confirmed residents had expressed concerns about being served cold food.

When interviewed on 12/9/14, at 4:00 p.m., the DON and administrator explained the facility staffing was according to the number of residents, resident acuity level and staff input.

On 12/10/2014, at 8:36 a.m., the therapeutic recreation director (TR), who facilitated the resident council, was interviewed about concerns of insufficient number of staff, call lights and food concerns. TR indicated the concerns were addressed to the management (administrator/DON). TR reported the management staff were working on improving staffing, yet staffing remained a concern for residents. TR indicated the dietary staff attended the resident council meetings, so assumed the dietary staff were taking care of the concerns of cold food.

On 12/10/14, at noon, the dietary manager (DM) indicated she had not attended the last two resident council meetings. DM stated she heard some of the residents complained about cold food, but nothing specific.

On 12/11/14, a test tray was prepared at

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F 244	Continued From page 5 breakfast. At 8:10 a.m. the test tray temperatures were checked with the DM. The cereal was 138 F (degrees Fahrenheit). The eggs were 112 F. At 8:20 a.m. the DM stated that she thought she used a thermometer which was not calibrated. On 12/11/14 at 12:10 p.m. the last tray was served to a patient, and the test tray temperatures were checked by the DM. The chicken was 128 F and the cauliflower was 110 F. The french fries temperature was not checked, but the DM touched them and indicated the french fries were cool to touch. The DM verified the plates were cool when the dining service started and the food temperatures were a problem.	F 244		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence;	F 272		1/21/15

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F 272	Continued From page 6 Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to comprehensively assess nutritional status for 4 of 4 residents (R25, R31, R77, R95) reviewed for nutrition. Findings include: R25 experienced significant weight loss, was not assessed by the facility's registered dietician, was not weighed consistently, did not receive high nutritional risk monitoring, and had a physician's order for a calorie count that was not completed timely and accurately. Review of the admission record revealed R25 was admitted on 6/25/14, with diagnoses including anemia, diabetes II with neurological manifestations, hypothyroidism, malaise, fatigue,	F 272	Resident R25, R31, R77 have discharged from facility. Resident R95 was assessed by Registered Dietician on 12/11/14. Facility Registered Dietician will visit facility weekly and maintain a monthly review for all residents that are nutritionally at high risk. Any resident determined to be at high nutritional risk will be assessed and put on a list. Assessments will continue quarterly and annually until nutritionally stable. Dietary Manager will audit the list of resident at high nutritional risk for completion of nutritional assessments weekly for a period of three months. All	

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F 272	Continued From page 7 vascular disease, kidney disease, and pressure ulcer. R25 was discharged on 9/27/14. The Weights and Vitals Summary form in the record indicated R25 weighed 264.6 lbs. (pounds) on 6/25/14. By 7/4/14 this R25's weight was 239.6 lbs. The lowest weight for R25 was recorded on 7/26/14 at 232.8 lbs.--a weight loss of more than 10% since admission. Six Dietary-Nutrition assessment forms were completed on R25, dated 7/2/14, 7/18/14, 7/23/14, 8/20/14, 8/21/14, and 9/19/14. All of these assessments were completed by the facility's certified dietary manager. There were no assessments found it the medical records that had been completed by the facility's registered dietician. According to the completed Dietary-Nutrition assessments, R25 should have been weighed daily and was on a controlled carbohydrate diet, until the 9/17/14 when the diet was changed to a regular diet, but daily weights continued. Many dates of daily weights were not present on the Weights and Vitals Summary form for R25. There was not documentation in the record that R25 had refused being weighed. The record also contained a physician's order, dated 8/21/14, that read, "Calorie count x 1 week, then update MD." The documentation of this calorie count could not be located in the record. On 12/11/14 an interview was conducted with the facility administrator regarding if there was another location where the calorie count could be documented. A copy of a Food Intake Record, was provided and showed what R25 ate on 8/25/14, 8/26/14, and 8/27/14, however did not show calorie calculations. The administrator also provided a copy of an email, dated 12/11/14, from	F 272	audits will be reviewed at QA to ensure compliance.	

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the facility's registered dietician that read, " You only sent me 3 days for the calorie count and I didn't realize that you wanted me to calculate it for you until today...This is my best estimate since I don't know exactly what foods he received at his meals, but he ate way over 1800 kcals [calories] on 8/25 and 8/26..."

When interviewed on 12/11/14, at 11 a.m. the facility's registered dietician reported she reviewed the diet of R25 when she visited this facility in September and made a note, but did not document that note in R25's record. When asked by the surveyor where this note may have been documented, the registered dietician replied she thought she may have left it on a report for the certified dietary manager at the facility.

When interviewed on 12/11/14, at 3:30 p.m. the facility administrator reported the staff at the facility were not aware of such a report and could not locate it.

R31 experienced significant weight loss, was not weighed consistently, was not assessed by the facility's registered dietician, and did not receive high nutritional risk monitoring.

Review of the admission record revealed R31 was admitted on 7/28/14, with diagnoses including aftercare for healing traumatic fracture of hip, pneumonia, and pressure ulcer. R31 was discharged on 9/17/14.

The Weights and Vitals Summary form in the record indicated R31 weighed 129 lbs. on 7/29/14. By 8/9/14 R31's weight was down to 110.4 lbs.--a weight loss of more than 10% since

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admission. This form indicated R31 was weighed seven times during her stay at the facility, weights were not taken every week on this resident, and R31's last weight before discharge was 112.9 lbs. on 9/12/14. There was not documentation in the record indicating R31 had refused being weighed.

Two Dietary-Nutrition assessment forms were completed on R31, dated 8/4/14 and 8/25/14. Both these assessments were done by the facility's certified dietary manager. No assessment done by the facility's registered dietician was found in the record. According to the completed Dietary-Nutrition assessments, the resident was on a mechanical soft diet, used a right curved spoon, and needed set up and assist with meals. The 8/25/14 assessment read that R31's weight was 111.4 lbs., BMI (body mass index) was 17.8, and her ideal body weight was 130 lbs. (The Center for Disease Control and Prevention website revealed that a BMI less than 18.5 for an adult is categorized as underweight.) This assessment also read R31 had a new order for a nutritional supplement twice daily.

When interviewed on 12/11/14, at 11:06 a.m. the facility's registered dietician reported she had no notes on R31 and the facility staff had never communicated anything to her regarding R31.

R77 received tube feedings and experienced weight loss, did not receive high nutritional risk monitoring, and had a physician's order for a calorie count that was not completed timely.

Review of the admission record revealed R77 was admitted on 9/26/14, with diagnoses including aftercare for healing of traumatic

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fracture of hip, adult failure to thrive, pressure ulcer, eating disorder, unspecified protein-calorie malnutrition, nausea, iron deficiency anemia, and irritable bowel syndrome. R77 remained in the facility.

The Weights and Vitals Summary form in the record showed that R77 weighed 111.2 lbs. on 9/30/14. By 10/16/14 R77's weight was down to 95.4 lbs--a weight loss of more than 10% since admission. The most recent weight recorded was 101.6 lbs. on 12/11/14.

Four Dietary-Nutrition assessment forms were completed on R77, dated 10/8/14, 10/27/14, 11/24/14, and 12/10/14. Three of these assessments were done by the facility's certified dietary manager. One assessment was done by the facility's registered dietician, dated 10/8/14. The registered dietician's assessment, dated 10/8/14, showed that R77 was at 86% of ideal body weight, with a BMI of 18.0, and weight gain was desirable. This assessment also contained calculations of calorie, protein, and fluids requirements for R77, along with calculations for tube feedings. The registered dietician's assessment listed the resident's diagnoses (including anorexia), medications that could affect nutritional status, intake patterns, some lab results, the use of a nutritional supplement, and the fact that R77 had a nasal gastric tube placed on 9/24/14 for tube feedings. When referring to R77's intake in this assessment, the registered dietician wrote, "Limited food records." The summaries in the assessments done by the certified dietary manager on 10/27/14, 11/24/14, and 12/10/14 were brief, including the resident's weight, order for daily weights, order for regular diet as tolerated, the fact that the resident made

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her needs known, the resident wanted mashed potatoes and gravy for lunch and supper each day, and R77's general intake of meals and liquid nutritional supplement. There was no documentation in the record of monitoring of this resident's condition by the registered dietician.

The record also contained a physician's order, dated 12/4/14, that read, "Dietary to review to make sure she is getting enough calories." The documentation of the calculation of this calorie count could not be located in the record. On 12/11/14 the surveyor asked the facility's certified dietary manager and administrator if there was another location where this calorie count could be documented and was provided with a copies of three Calorie Count Tracking forms, dated 12/4/14, 12/5/14, and 12/6/14, showing what R77 ate on those days, but no calorie calculations, and an undated, unsigned, copy of a piece of notebook paper that showed the calculations of calories and protein for those dates. At that time, the certified dietary manager stated that the calculations had not been completed before the surveyor requested them.

R95 experienced significant weight loss, weekly weights not done consistently, and was not on high nutritional risk monitoring.

Review of the admission record revealed R95 was admitted on 9/18/14, with diagnoses including hemiplegia affecting his dominant side, anorexia, kidney disease, and esophagitis. R95 remained in the facility.

The Weights and Vitals Summary form in the record showed that R95 weighed 180.2 lbs. on

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9/19/14. By 10/19/14 R95's weight was down to 150.2 lbs.--a weight loss of more than 10% since admission. The most recent weight recorded was 155.6 lbs. on 12/5/14. There were significant gaps between documented weights in the record--a weight on 9/23/14, then none until 10/19/14; a weight on 10/22/14, then weights only on 11/14/14 and 12/05/14. There was no documentation in the record of R95 refusing weights.

Five Dietary-Nutrition assessment forms were completed on this resident, dated 9/15/14, 9/30/14, 10/17/14, 11/14/14, and 12/5/14. All these assessments were done by the facility's certified dietary manager. No assessment done by the facility's registered dietician was found in the record. According to the completed Dietary-Nutrition assessments, R95 was on a regular diet. The 11/24/14 assessment read that a nutritional supplement three times daily had been added to R95"s nutritional plan of care on 10/19/14.

During interview on 12/11/14, at 10:50 a.m. The facility's registered dietician reported she had not assessed R95. Nobody at the facility informed her of any problems with him. The registered dietician reported the certified dietary manager at this facility generally did the nutritional assessments. She explained that the registered dietician did assessments for tube feeding residents, calorie count calculations, and assessments on residents who had nutritional issues. The registered dietician reported she does not maintain a list of residents at high nutritional risk and the facility did not have a high nutritional risk process. She explained she is a part-time worker and she did not believe

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providing high risk nutritional assessment and monitoring was part of her job. She reported she only visited the facility in January, February, July, September, and October in 2014. She went on to explain that another dietician had previously been employed by the facility who did the high nutritional risk monitoring and that dietician no longer worked at the facility. She was asked by the surveyor if a lack of high nutritional risk assessment and monitoring at the facility concerned her. She replied that it did concern her and she had shared those concerns with the administration of the facility and asked the administration for more registered dietician services. She indicated she did not have a plan for her next visit to the facility and she was unsure when that might be due to her limited work hours.

When interviewed on 12/11/14 at 12 p.m., the facility administrator was asked if she was aware that the facility registered dietician did not provide high nutritional risk assessment and monitoring of residents for the facility and that the registered dietician had not visited the facility since October 2014. The administrator reported the registered dietician should visit this facility 1-2 times monthly, at least monthly, and should provide all the professional services of a registered dietician to the facility. The administrator also reported she was not aware that the registered dietician was not providing all the necessary professional services and had not been at the facility since October.

Page 55 of the facility's undated Residents at Nutritional Risk policy read, "...Residents at risk for developing nutrition-related problems or medical/physicial [sic] problems as a result of

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F 272	Continued From page 14 poor nutritional status will be monitored. Food and fluid intake will be monitored as a critical element in the evaluation process...1. Residents with any of the following conditions should be considered at nutritional risk: a. Significant unplanned weight loss (5% in 30 days, 10% in 180 days)...c. Intake, less than 75% at 2 meals or more/day for 4 out of 7 days/week...f. Physical or behavioral inability to feed self g. Tube feeding h. Pressure ulcer - Stage 1-4, stasis ulcer, open wound i. Chronic vomiting/diarrhea or diagnosis of malabsorption j. Eliminates one or more of the four food groups...m. Diagnosis of malnutrition or abnormal lab values indicating malnutrition (i.e. albumin)...q. Failure to eat due to mood changes... 2. Resident names will be placed on the charting record when they meet any one of the above criteria. Their names will be removed when they are no longer at nutritional risk. a. Names can be added or deleted by the Consultant Dietitian or Dietary Department Head. b. Addition to the list can be made at the quarterly care conference, visits by the Consultant Dietician or when a significant change in condition occurs. c. The Consultant Dietitian will review and update this quarterly in the medical record and document progress..."	F 272		
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	F 278		1/21/15

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F 278	Continued From page 15 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess 1 of 3 residents (R43) in the sample reviewed for urinary incontinence. Findings include: R43 was observed, on 12/10/14, at 8:40 a.m., to ambulate to her room and toilet independently. During interview at 9:00 a.m. R43 stated that she ambulated independently and toileted independently. R43 indicated she wore a pullup, but "going to the bathroom is not a problem." Interview with nursing assistant (NA)-D on 12/10/14, revealed R43 was continent of urine,	F 278	Resident R43 had one episode of incontinence documented on 10/11/14. As this date was in the ARD period the MDS was correct as occasionally incontinent. Occasionally incontinent is defined as less than seven episodes during the ARD. RN referred to the nursing assistant statement as being inaccurate not the MDS. Resident□s care plan was updated to include occasional incontinence.	

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F 278	Continued From page 16 toileted independently, and there had not been a change in R43's toileting since admission. Review of R43's initial Minimum Data Set (MDS), dated July 18, 2014, indicated R43 was always continent of urine, however, the quarterly MDS, dated October 14, 2014, indicated R43 was occasionally incontinent (less than 7 episodes of incontinence). Interview with registered nurse (RN)-B, on 12/11/14 at 3:00 p.m., stated she completed R43's MDS on 10/14/14, confirmed the MDS was inaccurate, and R43 was continent of urine.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		1/21/15

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F 279	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to develop a comprehensive plan of care regarding hospice for 1 of 1 resident (R47) reviewed for hospice, and did not develop a comprehensive plan of care regarding sleep for 1 of 3 residents (R82) reviewed for the use of sleep medication. Findings include: The facility did not coordinate the plan of care with the hospice provider for R47. Record review on 12/09/14 revealed an admission to hospice form for R47, dated 3/14/14. The record also contained a current care plan from the hospice provider, and the facility care plan, dated 3/23/14, that included foci of terminal prognosis related to end stage cardiac disease and enrollment in hospice. There was a calendar for December 2014 in the record that was marked with the dates that the hospice nurse and hospice aide were to visit R47. This calendar showed that the hospice nurse was to visit on Mondays and Thursdays, and the hospice aide was to visit on Tuesdays and Fridays. No other professional disciplines were listed on this visit calendar. On 12/10/14 at 10:15 a.m., licensed practical nurse (LPN)-B and registered nurse (RN)-C were interviewed together and asked when the hospice nurse and hospice aide visited R47. They both replied that they were not sure. When asked if the hospice visit calendar was correct, they responded that they were not sure. They were	F 279	All residents on hospice have a calendar in the paper chart listing dates of hospice visits. All hospice calendars will be reviewed by hospice to include dates of visits for all disciplines. The calendars will be placed in a folder at the nurse□s stations and in the chart. All staff will be reeducated of new process. Hospice staff/NM/designee will audit calendars weekly to ensure all disciplines listed. Audits will be completed for a period of three months and reviewed at QA to ensure compliance. Resident R82 care plan has been updated to include need of sleep medication. DON/NM Designee will review all residents on medications for sleep and ensure need is addressed in the care plan. Care plans will be audited weekly at IDT that sleep medications are addressed. Audits will be completed for a period of three months and reviewed at QA to ensure compliance.	

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asked if any other hospice professionals visited R47, aside from a nurse and aide. They replied that they thought that a social worker visited R47, but they were not sure when. When asked how facility staff coordinated care with hospice staff during hospice visits, they stated that hospice staff talked with facility staff when they arrived and decided what care would be provided by hospice staff during that visit.

During interview on 12/11/14 at 8:30 a.m., LPN-C was asked the same questions and LPN-C also responded that she was not sure when the hospice nurse and aide visited, but she thought it was a couple times a week and that there may be a schedule somewhere. LPN-C also thought that she had seen hospice clergy and a hospice social worker visit, but did not know the schedule for those visits. She stated that she thought hospice aides gave an extra bath, nail care, or hand massage when visiting.

When interviewed on 12/11/14, at 8:35 a.m., nursing assistant (NA)-E was also asked the same questions and NA-E stated that she believed that the hospice aide visited twice weekly and the hospice nurse came once or twice a month. NA-E thought that the hospice aide visited on Tuesdays and Thursdays, and would give an extra bath, nail care, or hand massages. She was not sure if a hospice social worker or clergy visited R47.

R 82's plan of care did not address R82's need for medications to sleep or nonpharmacological interventions attempted to assist R82 to sleep.

Review of R82's medical record revealed

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F 279	Continued From page 19 physician orders for Trazodone HCL 50 mg. (milligrams), give 50 mg by mouth at bedtime for sleeplessness. (Trazadone HCL is an anti-depressant medication.) The medication was started on 7/23/14. R82 was admitted on 6/26/14 with diagnoses including dementia, colon cancer, hypertension (high blood pressure), and depression. Review of R82's plan of care did not reveal R 82's inability to sleep or any interventions to assist R82 to sleep. Interview with registered nurse (RN)-B on 12/11/14, at 3:00 p.m. verified sleep was not on the care plan and it should be, as R82 used a medication for sleep.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		1/21/15

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F 280	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to review and revise the care plan for 1 of 3 residents (R72) for positioning and pressure ulcers, for 1 of 6 residents (R72) for urinary incontinence and for 1 of 5 residents (R73) for behavior/side effect monitoring, sleep monitoring, and intake and output monitoring. Findings include: R72 did not have the plan of care updated for positioning, urinary incontinence and pressure ulcers. During numerous observations on 12/08/14, and 12/10/14, R72 was laying on the left side in bed and there was an undated, hand written note over the bed that instructed staff not to lay R72 on the right side. Review of the plan of care dated, 1/18/14, directed staff for mobility "Extensive assist of two staff to reposition every two hours and prn [whenever necessary] in bed or wheel chair and with staff assist to reposition from side to side as will allow." R72's cognition was impaired according to the form titled, Brief Interview for Mental Status (BIMS) dated, 1/31/14. R72 had a diagnosis of Dementia and was receiving hospice services. Documentation in the interdisciplinary team notes dated 11/30/14, at 7:36 p.m. read, "Patient noted with a purple to black discoloration to right hip	F 280	Resident R72 passed away on 12/11/14. DON/NM/Designee will review all residents with pressure ulcers to ensure care plan is up to date. Care plans will be audited weekly at IDT for a period of three months and reviewed at QA to ensure compliance. R73's order for strict I&O and was discontinued 12/31/14. R73 MAR was updated to include documentation for the number of hours resident sleeps. All residents on strict I&O and orders for documentation for number of hours of sleep will be reviewed for documentation in MAR/TAR. DON/NM/Designee will audit residents with orders for strict I&O and sleep hours documentation weekly at IDT for a period of three months and reviewed at QA to ensure compliance.	

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F 280	Continued From page 21 area measuring 2 cm [centimeter] by 1.5 cm. Skin is intact and area not warm to touch. Per MD [medical doctor] orders we will reposition patient off her right hip every 2 hours till area improves." The form titled Braden and Skin Risk Data Collection form was re-done 11/30/14 at 7:50 p.m. and R72 changed from moderate risk of developing pressure ulcers to very high risk for developing pressure ulcers. The Braden Summary read, "Patient has poor intake, immobile, and often lies to her right side while in bed. Refuses cares and is on hospice. Resident requires moderate assist in moving, is chairfast and immobile. Resident incontinent and high risk of developing pressure areas. Resident to be turned and offloaded every two hours. Monitor area till resolved. No abuse, neglect suspected." The plan of care was not updated to reflect this information. On 12/10/14, at 10:15 a.m. during observation of cares, it was noted that a nickel size scabbed area to the skin of the right hip and two pin point skin pressure areas on the left hip. Interviews with nurses on 12/10/14, at 11:00 a.m., director of nursing (DON) registered nurse (RN)-A, licensed practical nurse (LPN)-A and the hospice RN, confirmed they were not aware of the nickel size scabbed area to the right hip or of the new developing areas on the left hip. RN-A validated an assessment would be completed immediately and the plan of care updated. The policy dated 3/2012, and titled Care Plan Policy and Procedure, directed staff, "The care plan is to be changed and updated as the care changes for the resident and as the resident changes. It is to be current at all times."	F 280		

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F 280	Continued From page 22 R73 was admitted 7/1/14. The current physician orders, dated 12/14, directed the staff to monitor the hours of sleep every shift (qshift) and to monitor the potential side effects of the antidepressant and to document qshift. Strict intake and output (I & O) qshift related to urinary tract infection was to be completed. The current care plan last updated 10/14/14, did not address side effect monitoring for the antidepressant usage. Although the care plan identified urinary incontinence and urinary infection, intake and output monitoring was not identified. Sleep monitoring and medication for sleep was not addressed. The treatment record indicated to monitor hours of sleep qshift, however the treatment record for December had check marks and no actual number of hours of sleep. The November and December qshift intake and output record indicated no output documented. On 12/11/2014, at 2:45 p.m. registered nurse (RN)-A, was interviewed and indicated antidepressant usage and side effects should be addressed on the care plan along with the I & O and the sleep monitoring.	F 280		
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.	F 282		1/21/15

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F 282	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on document review, observation and interview, the facility failed to provide services in accordance with each resident's written plan of care for 2 of 3 residents (R33 and R62) in the sample who had been identified at risk for developing a pressure ulcer and required assistance with repositioning and incontinence care. Findings include: R33's care plan dated 8/22/12, directed staff "Assist of 1 to turn and reposition every 2 hrs [hours] while in bed or w/c [wheelchair]. 1 assist to check brief Q [every] 2hrs and change PRN [whenever necessary]. R33 was severely cognitively impaired due to diagnosis of Alzheimer's disease according to the Minimum Data Set (MDS) completed 4/28/14. During continuous observations on 12/10/14, from 7:15 a.m. until 10:27 a.m. R33 remained seated in the wheel chair for 3 1/4 hours without a position change or incontinence check. Interviews with nursing assistants, (NA)-A, (NA)-B and (NA)-C revealed, they work as a team and there was not a specific NA assigned to R33, but NA-C actually got R33 up in the morning and stated, "I got her up around 6:30 a.m.." The three nursing assistants validated they provided no cares for R33 since getting her up at 6:30 a.m.. R33 required a position change and incontinence check every two hours. R62's care plan dated 6/10/14, directed staff: "Toileting: 2 assist to check and change Q2hrs	F 282	Resident R33 was assessed and determined that resident could tolerate q3hr repositioning intervals. R33 care plan was updated to reflect change. Resident R62 remains on q2hr repositioning interval. All units have been split into groups. Each group has a specific nursing assistant assigned to each group. Staff were educated on new group assignments. NM/designee will audit positioning for three residents a week for a period of one month, then one resident a week for two months. Repositioning audits will be reviewed at QA to ensure compliance.	

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and PRN her request. Turn/reposition/off load Q 2 hrs and prn." R62 was cognitively intact according to the MDS completed 11/25/14.

R62's active diagnoses from the 11/25/14 MDS listed, but was not limited to, paraplegia, diabetes mellitus, cervical spinal stenosis and a stage 4 pressure ulcer to coccyx present on admission 12/18/13. (Stage IV Pressure Ulcer - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.)

During observations on 12/8/14, at 3:45 p.m. R62 had a position change to be on her back. During continuous observation, R33 remained on her back and did not have a position change as of 7:30 p.m. when surveyor left, two hours and forty five minutes. During observation on 12/10/14, at 7:15 a.m. R33 was repositioned to her back. During continuous observations, R33 remained on her back and did not have a position change until 10:00 a.m. two hours and forty five minutes when NA-A and NA-B approached R33.

When interviewed on 12/10/14, at 8:26 a.m. R62 verified the staff had been instructed to change her position every two hours but the staff did not always follow the two hour plan. R62 further clarified, if she fell asleep, staff did not come in the room. R62 wanted the staff to come every two hours so that she did not have to use the call light to get the attention of staff.

The policy dated 3/2012 and titled, Care Plan Policy and Procedure, read, "The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of

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ANGELS CARE CENTER	**300 NORTH DOW STREET CANNON FALLS, MN 55009**

(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 282	Continued From page 25 practicable function possible."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to coordinate the plan of care with the hospice provider for 1 of 1 resident (R47) reviewed for hospice. Findings include: Record review on 12/09/14 revealed an admission to hospice form for R47, dated 3/14/14. The record also contained a current care plan from the hospice provider, and the facility care plan, dated 3/23/14, that included foci of terminal prognosis related to end stage cardiac disease and enrollment in hospice. There was a calendar for December 2014 in the record that was marked with the dates that the hospice nurse and hospice aide were to visit R47. This calendar showed the hospice nurse was to visit on Mondays and Thursdays, and the hospice aide was to visit on Tuesdays and Fridays. No other professional disciplines were listed on this visit calendar.	F 309	All residents on hospice have a calendar in the paper chart listing dates of hospice visits. All hospice calendars will be reviewed by hospice to include dates of visits for all disciplines. The calendars will be placed in a folder at the nurse□s stations and in the chart. All staff will be reeducated of new process. Hospice staff/NM/disgness will audit calendars weekly. Audits will be completed for a period of three months and reviewed at QA to ensure compliance.	1/21/15

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F 309	Continued From page 26	F 309		

On 12/10/14 at 10:15 a.m., licensed practical nurse (LPN)-B and registered nurse (RN)-C were interviewed together and asked when the hospice nurse and hospice aide visited R47. They both replied that they were not sure. When asked if the hospice visit calendar was correct, they responded that they were not sure. They were asked if any other hospice professionals visited R47, aside from a nurse and aide. They replied they thought that a social worker visited R47, but they were not sure when. When asked how facility staff coordinated care with hospice staff during hospice visits, they stated that hospice staff talked with facility staff when they arrived and decided what care would be provided by hospice staff during that visit.

During interview on 12/11/14 at 8:30 a.m., a nurse, (LPN)-C was asked the same questions by a surveyor and also responded that she was not sure when the hospice nurse and aide visited, but she thought it was a couple times a week and that there may be a schedule somewhere. She also thought that she had seen hospice clergy and a hospice social worker visit, but did not know the schedule for those visits. She stated that she thought hospice aides gave R47 an extra bath, nail care, or hand massage when visiting.

When interviewed on 12/11/14 at 8:35 a.m., nursing assistant (NA)-E was also asked the same questions and stated that she believed that the hospice aide visited twice weekly and the hospice nurse came once or twice a month. She thought that the hospice aide visited on Tuesdays and Thursdays, and would give an extra bath, nail care, or hand massages. She was not sure if a hospice social worker or clergy visited R47.

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F 314	Continued From page 27	F 314		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 4 residents (R72, R33, R62) in the sample reviewed for pressure ulcers received care and services necessary to minimize the risk for development of pressure ulcers and heal existing pressure ulcers. Findings include: R72 acquired three pressure ulcers while residing in the facility from 11/30/14 through 12/10/14. During numerous observations on 12/8/14, and 12/10/14, from 8:00 a.m. until 10:22 a.m.(two hours, twenty-two minutes) R72 was lying on the left side in bed. Above the bed was an undated, hand written note instructing staff not to lie R72 on the right side. On 12/10/14, at 10:22 a.m. during an observation of R72's cares, a nickel size scabbed area was noted on the resident's right hip, as well as two pin point skin pressure ulcers on the left hip.	F 314	Resident R72 was on hospice and passed away on 12/11/14. It was determined by hospice RN R72 pressure ulcers were unavoidable Kennedy Terminal Ulcers. All nursing staff will be in serviced on Facility Policy and Procedure for the treatment/prevention of pressure ulcers and weekly bath audits. DON/NM/Designee will complete wound rounds weekly on all residents with pressure ulcers to determine effectiveness of interventions and make changes when no improvement noted. Resident R33 was assessed and determined that resident could tolerate q3hr repositioning intervals. R33 care plan was updated to reflect change. Resident R62 remains on q2hr repositioning interval. All units have been split into groups.	1/21/15

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F 314	Continued From page 28 Interdisciplinary team notes dated 11/30/14, at 7:36 p.m. read, "Patient noted with a purple to black discoloration to right hip area measuring 2 cm [centimeter] by 1.5 cm. Skin is intact and area not warm to touch. Per MD [medical doctor] orders we will reposition patient off her right hip every 2 hours till area improves." A Braden and Skin Risk Data Collection form was revised 11/30/14, after R72 changed from moderate risk of developing pressure ulcers to very high risk for developing pressure ulcers. The Braden summary read, "Patient has poor intake, immobile, and often lies to her right side while in bed. Refuses cares and is on hospice. Resident requires moderate assist in moving, is chairfast and immobile. Resident incontinent and high risk of developing pressure areas. Resident to be turned and offloaded every two hours. Monitor area till resolved. No abuse, neglect suspected." The care plan was not updated to reflect the changes. Although R72 was assessed at a high risk of developing pressure ulcers, no further interventions were initiated according to the facility Wound Care Protocols which directed implementation of the weekly wound documentation, and to re-evaluate bed and wheelchair surface. R72 did not have a weekly bath body audit completed on 12/3/14, per facility policy. When interviewed for the missing bath body audit on 12/12/14, at 8:33 a.m. the registered nurse, (RN)-A stated, "They did not do it." An interview with a group of nurses including the director of nursing (DON), registered nurse (RN)-A, licensed practical nurse (LPN)-A, and the hospice RN, was conducted on 12/10/14, at 11:00	F 314	Each group has a specific nursing assistant assigned to each group. Staff will be educated on new group assignments. NM/DON/Designee will conduct weekly audits of skin/bath checks for a period of three months. NM/designee will audit positioning for three residents a week for a period of one month, then one resident a week for two months. All audits will be reviewed at QA to ensure compliance.	

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a.m. The nurses each confirmed they were unaware of the nickel size scabbed area to the right hip or of the new developing areas on the left hip. RN-A validated an assessment should have been completed immediately and the care plan updated. RN-A verified the nurse who documented on 11/30/14, at 7:36 p.m. had not followed the facility's 8/11 policy, Prevention and Treatment of Skin Breakdown. They also acknowledged the facility's form, Wound Weekly Observation Tool, should have been implemented on 11/30/14, but was not completed until 12/10/14.

On 12/10/14, at 11:20 a.m. The hospice RN confirmed the mattress on R72's bed was not a pressure relieving mattress but was a raised edge mattress.

The facility's form, Wound Weekly Observation Tool, dated as completed 12/10/14 at 1:59 p.m., indicated the resident had an acquired, pressure ulcer worsening with necrotic tissue present (brown, black, leather, scab-like. Wound measurement length 1.5 millimeter (mm), width 1.9 mm, and depth 0.2 mm. Wound progress deteriorated.

A Wound Weekly Observation Tool dated 12/10/14, completed at 2:08 p.m. described newly acquired pressure areas to the left hip both measuring 0.1 by 0.1 mm, with 2 pin point areas to the left hip, and unable to measure depth.

A Wound Weekly Observation Tool dated 12/10/14, completed at 2:13 p.m. indicated new acquired pressure areas to the coccyx that measured 2 mm length by 1.5 mm width by 0.2 mm depth. Further directions included: "Hospice

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to bring in overlay [mattress]. repo q1hrs and prn [reposition every hour and as needed]. Res. is not eating or drinking; do not anticipate improvement due to she is actively dying."

R72's care plan dated 1/18/14, directed staff to provide "Extensive assist of two staff to reposition every two hours and prn in bed or wheel chair and with staff assist to reposition from side to side as will allow."

R72's cognition was impaired according to a Brief Interview for Mental Status dated 1/31/14. R72 had a diagnosis of dementia and was receiving hospice services.

R62 did not have a position change for two hours and forty-five minutes during two observations.

During observations on 12/8/14, from 4:45 p.m. until 7:30 p.m., R62 remained lying on her back in bed for two hours and forty-five minutes without a position change. During continuous observations on 12/10/14, from 7:15 a.m. until 10:00 a.m., R62 remained lying on her back in bed for two hours and forty-five minutes without a position change. On 12/10/14, R62's skin, after waiting two hours and forty five minutes for a position change, revealed bright red areas with crevices and craters on the buttocks and posterior thighs where there had been wrinkling of the incontinence brief and clothing. Nursing assistants, (NA)-A and (NA)-B verified the condition of the R62's skin at the time of the observation.

When interviewed on 12/8/14, at 5:24 p.m., R62 expressed concern that staff did not automatically come in and reposition her every two hours.

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F 314	Continued From page 31 Sometimes when R62 fell asleep or did not turn on her call light the staff did not come in to reposition her at least every two hours. R62 expressed concern about being paralyzed with a healing Stage IV pressure ulcer and the repositioning was very important to help in the healing process. R62 reported she told staff repositioning every two hours was a priority. (Stage IV Pressure Ulcer - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) R62's care plan dated 6/10/14, directed staff, "Turn/reposition/off load Q [every] 2 hrs [hours]and prn [whenever necessary]." R62 was cognitively intact according to the MDS [Minimum Data Set], completed 11/25/14. The Braden Scale for predicting Pressure Sore Risk, dated 11/26/14, indicated R33 was at mild risk for pressure ulcer development. R62's active diagnoses from the MDS listed, but was not limited to, paraplegia, diabetes mellitus, cervical spinal stenosis and a Stage IV pressure ulcer to coccyx present on admission, dated 12/18/13. Interviews with nursing assistants, (NA)-A, NA-B and NA-C on 12/10/14, at 11:00 a.m. revealed they worked as a team and there was not a specific NA assigned to R62. The three NAs validated R62 did not have her position changed every two hours and there was not a system to ensure the every two hours was tracked to enhance the communication amongst the NAs. R33 did not have a position change for three hours and fifteen minutes.	F 314		

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F 314	Continued From page 32 During continuous observations on 12/10/14, from 7:15 a.m. until 10:27 a.m. R33 remained seated in the wheel chair for three hours and fifteen minutes without a position change. R33 was assisted to bed by NA-A and NA-B and the use of a mechanical lift on 12/10/14, at 10:27 a.m.. R33's skin was bright red with crevices and craters on the buttocks and posterior thighs where there had been wrinkling of the incontinence brief and clothing. NA-A and NA-B verified the condition of the resident's skin at the time of the observation. R33's care plan dated 8/22/12, directed staff, "Assist of 1 to turn and reposition Q 2 hrs while in bed or w/c [wheel chair]. 1 assist to check brief Q 2hrs and change PRN. R33 was severely cognitively impaired due to diagnosis of Alzheimer's disease, according to the Minimum Data Set (MDS) completed 4/28/14. The Braden Scale for predicting Pressure Sore Risk dated 10/7/14, indicated R33 was at high risk for pressure ulcer development	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		1/21/15

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F 315	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 4 residents (R33, R62, R72) in the sample,who were identified as incontinent of urine, received the necessary care and services to manage incontinence. Findings include: R62 did not receive incontinence care for two hours and forty-five minutes during two observations. During observations on 12/8/14, from 4:45 p.m. until 7:30 p.m., R62 remained lying on her back in bed for two hours and forty-five minutes without a incontinence check. During continuous observations on 12/10/14, from 7:15 a.m. until 10:00 a.m., R62 remained lying on her back in bed for two hours and forty-five minutes without an incontinence check. R62's skin, after waiting two hours and forty five minutes for a incontinence check on 12/10/14 at 10:00 a.m., revealed bright red areas with crevices and craters on the buttocks and posterior thighs where there had been wrinkling of the incontinence brief and clothing. R62 was incontinent a large bowel movement and urine. Nursing assistants, (NA)-A and (NA)-B verified the condition of the resident's skin at the time of the observation. When interviewed on 12/8/14, at 5:24 p.m., R62 expressed concern that staff did not automatically	F 315	R62 has discharged from facility. R72 has passed away. R33 was re-assessed for a toileting plan. Care plan was updated to q3 hr and prn check and change. Facility reorganized the function of each unit by assigning residents on units into individual nursing assistant assignments to ensure accountability for resident needs being met. Staff will be educated on new procedure. NM/designee will audit toileting for three residents a week for a period of one month, then one resident a week for two months. Audits will be reviewed at QA to ensure compliance.	

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F 315	Continued From page 34 come in and check for incontinence every two hours. Sometimes if R62 fell asleep or did not put her call light on, the staff did not come in to check for incontinence at least every two hours. R62 expressed concern about being paralyzed with a healing stage IV pressure ulcer and the incontinence cleansing was very important to help in the healing process. R62 had told staff incontinence care every two hours was a priority. (Stage IV Pressure Ulcer - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.) R62's care plan dated 6/10/14, directed staff, "Check and change Q [every] 2 hrs [hours]and prn [whenever necessary]." R62 was cognitively intact according to the Minimum Data Set (MDS) completed 11/25/14. R62's active diagnoses from the MDS listed, but was not limited to, paraplegia, diabetes mellitus, cervical spinal stenosis and a Stage 4 pressure ulcer to coccyx present at admission on 12/18/13. Interviews with nursing assistants, (NA)-A, NA-B and NA-C on 12/10/14, at 11:00 a.m. revealed they work as a team and there was not a specific NA assigned to R62. The three nursing assistants validated R62 did not have a check and change every two hours and there was not a system to track incontinence check and changes to enhance the communication amongst the nursing assistants. R33 did not have a incontinence check and change for three hours and fifteen minutes.	F 315		

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F 315	Continued From page 35 During continuous observations on 12/10/14, from 7:15 a.m. until 10:27 a.m. R33 remained seated in the wheel chair for three hours and fifteen minutes without a incontinence check and change. R33 was assisted to bed by NA-A, NA-B and the use of a mechanical lift on 12/10/14, at 10:27 a.m.. R33 was incontinent a large amount of loose bowel movement that was up to R33's lumbar area of the back and incontinent a large amount of urine, as the brief was completely saturated. R33's skin was bright red with crevices and craters on the buttocks and posterior thighs where there had been wrinkling of the incontinence brief and clothing. NA-A and NA-B verified the condition of the resident's skin at the time of the observation. R33's care plan dated 8/22/12, directed staff "Assist to check brief Q2hrs and change PRN,[whenever necessary], peri-care and apply barrier cream after incont. [incontinence] R33 was severely cognitively impaired due to diagnosis of Alzheimer's disease according to the MDS completed 4/28/14. The facility failed to provide R72 with incontinence care as directed by the plan of care. R72 was incontinent of urine, at risk for urinary tract infection and required assistance with incontinence care every two hours. Review of the plan of care dated, 1/18/14, directed staff for toileting with alteration in elimination requiring the Check and Change Program every 2 hours for incontinence.	F 315		

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F 315	Continued From page 36 R72's cognition was impaired according to the form titled, Brief Interview for Mental Status (BIMS) dated, 1/31/14. R72 had a diagnosis of Dementia and was receiving hospice services. During numerous observations on 12/08/14, and 12/10/14, from 8:00 a.m. until 10:22 a.m., R72 was not checked for incontinence and did not receive incontinence care. Observation on 12/10/14, at 10:22 a.m., revealed R72 was incontinent a moderate amount of urine. Interviews with nursing assistants, (NA)-A, NA-B and NA-C on 12/10/14, at 11:00 a.m. revealed they work as a team and there was not a specific NA assigned to R72. The three nursing assistants validated R72 did not have a check and change every two hours and there was not a system to track completion of incontinence care to enhance the communication amongst the nursing assistants.	F 315		
F 325 SS=E	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	F 325		1/21/15

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F 325	Continued From page 37 by: Based on document review and interview, the facility failed to provide comprehensive assessment and consistent monitoring regarding nutritional status for 4 or 4 residents (R25, R31, R77, R95) reviewed for nutrition. Findings include: R25 experienced significant weight loss, was not assessed by the facility's registered dietician, was not weighed consistently, did not receive high nutritional risk monitoring, and had a physician's order for a calorie count that was not completed timely and accurately. Review of the admission record revealed R25 was admitted on 6/25/14, with diagnoses including anemia, diabetes II with neurological manifestations, hypothyroidism, malaise, fatigue, vascular disease, kidney disease, and pressure ulcer. R25 was discharged on 9/27/14. The Weights and Vitals Summary form in the record indicated R25 weighed 264.6 lbs. (pounds) on 6/25/14. By 7/4/14 this R25's weight was 239.6 lbs. The lowest weight for R25 was recorded on 7/26/14 at 232.8 lbs.--a weight loss of more than 10% since admission. Six Dietary-Nutrition assessment forms were completed on R25, dated 7/2/14, 7/18/14, 7/23/14, 8/20/14, 8/21/14, and 9/19/14. All these assessments were completed by the facility's certified dietary manager. No assessment completed by the facility's registered dietician was found in the record. According to the completed Dietary-Nutrition assessments, R25 should have been weighed daily and was on a controlled	F 325	Resident R25, R31, R77 have discharged from facility. Resident R95 was assessed by Registered Dietician on 12/11/14. Facility Registered Dietician will visit facility weekly and maintain a monthly review for all residents that are nutritionally at high risk. Any resident determined to be at high nutritional risk will be assessed and put on a list. Assessments will continue quarterly and annually until nutritionally stable. Dietary Manager will audit the list of resident at high nutritional risk for completion of nutritional assessments weekly for a period of three months. All audits will be reviewed at QA to ensure compliance.	

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carbohydrate diet, until the 9/17/14 when the diet was changed to a regular diet, but daily weights continued. Many dates of daily weights were not present on the Weights and Vitals Summary form for R25. There was not documentation in the record that R25 had refused being weighed.

The record also contained a physician's order, dated 8/21/14, that read, "Calorie count x 1 week, then update MD." The documentation of this calorie count could not be located in the record. On 12/11/14 the surveyor asked the facility administrator if there was another location where this calorie count could be documented and was provided with a copy of a Food Intake Record, dated 8/25/14, 8/26/14, and 8/27/14, showing what R25 ate on those days, but no calorie calculations. The administrator also provided a copy of an email, dated 12/11/14, from the facility's registered dietician that read, " You only sent me 3 days for the calorie count and I didn't realize that you wanted me to calculate it for you until today...This is my best estimate since I don't know exactly what foods he received at his meals, but he ate way over 1800 kcals [calories] on 8/25 and 8/26..."

When interviewed on 12/11/14, at 11 a.m. the facility's registered dietician reported she reviewed the diet of R25 when she visited this facility in September and made a note, but did not document that note in R25's record. When asked by the surveyor where this note may have been documented, the registered dietician replied she thought she may have left it on a report for the certified dietary manager at the facility.

When interviewed on 12/11/14, at 3:30 p.m. the facility administrator reported the staff at the

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facility were not aware of such a report and could not locate it.

R31 experienced significant weight loss, was not weighed consistently, was not assessed by the facility's registered dietician, and did not receive high nutritional risk monitoring.

Review of the admission record revealed R31 was admitted on 7/28/14, with diagnoses including aftercare for healing traumatic fracture of hip, pneumonia, and pressure ulcer. R31 was discharged on 9/17/14.

The Weights and Vitals Summary form in the record indicated R31 weighed 129 lbs. on 7/29/14. By 8/9/14 R31's weight was down to 110.4 lbs.--a weight loss of more than 10% since admission. This form indicated R31 was weighed seven times during her stay at the facility, weights were not taken every week on this resident, and R31's last weight before discharge was 112.9 lbs. on 9/12/14. There was not documentation in the record indicating R31 had refused being weighed.

Two Dietary-Nutrition assessment forms were completed on R31, dated 8/4/14 and 8/25/14. Both these assessments were done by the facility's certified dietary manager. No assessment done by the facility's registered dietician was found in the record. According to the completed Dietary-Nutrition assessments, the resident was on a mechanical soft diet, used a right curved spoon, and needed set up and assist with meals. The 8/25/14 assessment read that R31's weight was 111.4 lbs., BMI (body mass index) was 17.8, and her ideal body weight was 130 lbs. (The Center for Disease Control and

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Prevention website revealed that a BMI less than 18.5 for an adult is categorized as underweight.) This assessment also read R31 had a new order for a nutritional supplement twice daily.

When interviewed on 12/11/14, at 11:06 a.m. the facility's registered dietician reported she had no notes on R31 and the facility staff had never communicated anything to her regarding R31.

R77 received tube feedings and experienced weight loss, did not receive high nutritional risk monitoring, and had a physician's order for a calorie count that was not completed timely.

Review of the admission record revealed R77 was admitted on 9/26/14, with diagnoses including aftercare for healing of traumatic fracture of hip, adult failure to thrive, pressure ulcer, eating disorder, unspecified protein-calorie malnutrition, nausea, iron deficiency anemia, and irritable bowel syndrome. R77 remained in the facility.

The Weights and Vitals Summary form in the record showed that R77 weighed 111.2 lbs. on 9/30/14. By 10/16/14 R77's weight was down to 95.4 lbs--a weight loss of more than 10% since admission. The most recent weight recorded was 101.6 lbs. on 12/11/14.

Four Dietary-Nutrition assessment forms were completed on R77, dated 10/8/14, 10/27/14, 11/24/14, and 12/10/14. Three of these assessments were done by the facility's certified dietary manager. One assessment was done by the facility's registered dietician, dated 10/8/14. The registered dietician's assessment, dated

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10/8/14, showed that R77 was at 86% of ideal body weight, with a BMI of 18.0, and weight gain was desirable. This assessment also contained calculations of calorie, protein, and fluids requirements for R77, along with calculations for tube feedings. The registered dietician's assessment listed the resident's diagnoses (including anorexia), medications that could affect nutritional status, intake patterns, some lab results, the use of a nutritional supplement, and the fact that R77 had a nasal gastric tube placed on 9/24/14 for tube feedings. When referring to R77's intake in this assessment, the registered dietician wrote, "Limited food records." The summaries in the assessments done by the certified dietary manager on 10/27/14, 11/24/14, and 12/10/14 were brief, including the resident's weight, order for daily weights, order for regular diet as tolerated, the fact that the resident made her needs known, the resident wanted mashed potatoes and gravy for lunch and supper each day, and R77's general intake of meals and liquid nutritional supplement. There was no documentation in the record of monitoring of this resident's condition by the registered dietician.

The record also contained a physician's order, dated 12/4/14, that read, "Dietary to review to make sure she is getting enough calories." The documentation of the calculation of this calorie count could not be located in the record. On 12/11/14 the surveyor asked the facility's certified dietary manager and administrator if there was another location where this calorie count could be documented and was provided with a copies of three Calorie Count Tracking forms, dated 12/4/14, 12/5/14, and 12/6/14, showing what R77 ate on those days, but no calorie calculations, and an undated, unsigned, copy of a piece of

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notebook paper that showed the calculations of calories and protein for those dates. At that time, the certified dietary manager stated that the calculations had not been completed before the surveyor requested them.

R95 experienced significant weight loss, weekly weights not done consistently, and was not on high nutritional risk monitoring.

Review of the admission record revealed R95 was admitted on 9/18/14, with diagnoses including hemiplegia affecting his dominant side, anorexia, kidney disease, and esophagitis. R95 remained in the facility.

The Weights and Vitals Summary form in the record showed that R95 weighed 180.2 lbs. on 9/19/14. By 10/19/14 R95's weight was down to 150.2 lbs.--a weight loss of more than 10% since admission. The most recent weight recorded was 155.6 lbs. on 12/5/14. There were significant gaps between documented weights in the record--a weight on 9/23/14, then none until 10/19/14; a weight on 10/22/14, then weights only on 11/14/14 and 12/05/14. There was no documentation in the record of R95 refusing weights.

Five Dietary-Nutrition assessment forms were completed on this resident, dated 9/15/14, 9/30/14, 10/17/14, 11/14/14, and 12/5/14. All these assessments were done by the facility's certified dietary manager. No assessment done by the facility's registered dietician was found in the record. According to the completed Dietary-Nutrition assessments, R95 was on a regular diet. The 11/24/14 assessment read that a

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nutritional supplement three times daily had been added to R95"s nutritional plan of care on 10/19/14.

During interview on 12/11/14, at 10:50 a.m. The facility's registered dietician reported she had not assessed R95. Nobody at the facility informed her of any problems with him. The registered dietician reported the certified dietary manager at this facility generally did the nutritional assessments. She explained that the registered dietician did assessments for tube feeding residents, calorie count calculations, and assessments on residents who had nutritional issues. The registered dietician reported she does not maintain a list of residents at high nutritional risk and the facility did not have a high nutritional risk process. She explained she is a part-time worker and she did not believe providing high risk nutritional assessment and monitoring was part of her job. She reported she only visited the facility in January, February, July, September, and October in 2014. She went on to explain that another dietician had previously been employed by the facility who did the high nutritional risk monitoring and that dietician no longer worked at the facility. She was asked by the surveyor if a lack of high nutritional risk assessment and monitoring at the facility concerned her. She replied that it did concern her and she had shared those concerns with the administration of the facility and asked the administration for more registered dietician services. She indicated she did not have a plan for her next visit to the facility and she was unsure when that might be due to her limited work hours.

When interviewed on 12/11/14 at 12 p.m., the

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facility administrator was asked if she was aware that the facility registered dietician did not provide high nutritional risk assessment and monitoring of residents for the facility and that the registered dietician had not visited the facility since October 2014. The administrator reported the registered dietician should visit this facility 1-2 times monthly, at least monthly, and should provide all the professional services of a registered dietician to the facility. The administrator also reported she was not aware that the registered dietician was not providing all the necessary professional services and had not been at the facility since October.

Page 55 of the facility's undated Residents at Nutritional Risk policy read, "...Residents at risk for developing nutrition-related problems or medical/physicial [sic] problems as a result of poor nutritional status will be monitored. Food and fluid intake will be monitored as a critical element in the evaluation process...1. Residents with any of the following conditions should be considered at nutritional risk: a. Significant unplanned weight loss (5% in 30 days, 10% in 180 days)...c. Intake, less than 75% at 2 meals or more/day for 4 out of 7 days/week...f. Physical or behavioral inability to feed self g. Tube feeding h. Pressure ulcer - Stage 1-4, stasis ulcer, open wound i. Chronic vomiting/diarrhea or diagnosis of malabsorption j. Eliminates one or more of the four food groups...m. Diagnosis of malnutrition or abnormal lab values indicating malnutrition (i.e. albumin)...q. Failure to eat due to mood changes... 2. Resident names will be placed on the charting record when they meet any one of the above criteria. Their names will be removed when they are no longer at nutritional risk. a. Names can be added or deleted by the

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F 325	Continued From page 45 Consultant Dietitian or Dietary Department Head. b. Addition to the list can be made at the quarterly care conference, visits by the Consultant Dietician or when a significant change in condition occurs. c. The Consultant Dietitian will review and update this quarterly in the medical record and document progress..."	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329		1/21/15

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F 329	Continued From page 46 Based on document review and interview, the facility failed to provide monitoring of behaviors, monitoring of side effects, diabetic monitoring, sleep monitoring, and documentation of effectiveness of non-pharmacological sleep interventions for 2 of 5 residents (R73, R82) reviewed for unnecessary medications. Findings include: Review of the medical record revealed R73 was admitted 7/1/14 with diagnoses which included diabetes mellitus (DM), systemic lupus erythematosus, muscle weakness, encephalopathy, urinary tract infection, and depression. The current physician orders were reviewed and revealed and included the following orders: Lantus Insulin (diabetes medication) 10 units once a day (qd) at 7:00 a.m. increased on 12/7/14. Novolog Insulin (diabetes medication) 6 units at lunch increased on 12/7/14 Novolog Insulin 6 units at supper increased on 12/7/14 Novolog Insulin 8 units at breakfast increased on 12/7/14 Lantus Insulin 8 units at hour of sleep (HS) 9 p.m. increased on 12/9/14 Celexa (an antidepressant) 20 mg (milligram) in the a.m (morning). and antidepressant started 7/31/14 Trazodone (an antidepressant) 50 mg at HS may repeat once for sleep started on 12/4/14. The physician orders directed the staff to monitor the hours of sleep every shift (qshift) and to monitor the blood sugars 4 times a day (qid)	F 329	Resident R73 Accucheck monitoring was corrected to require a value for hs bloodsugar vs a check mark. All residents with accucheck orders were reviewed for accuracy. NM/DON/Designee will audit accucheck orders weekly at IDT for a period of three months. All audits will be reviewed at QA for accuracy. R73 order for strict I&O and was discontinued 12/31/14. R73 MAR was updated to include documentation for the number of hours resident sleeps. All residents on strict I&O and orders for documentation for number of hours of sleep will be reviewed for documentation in MAR/TAR. Orders will continue to be audited weekly at IDT for a period of three months and reviewed at QA to ensure compliance. Resident R82 care plan has been updated to include a need for need of sleep medication. DON/NM Designee will review all residents on medications for sleep and ensure problem is addressed in the care plan. Care plans will be audited weekly at IDT that sleep medications are addressed in the care plan. Audits will be completed for a period of three months and reviewed at QA to ensure compliance.	

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F 329	Continued From page 47 including bedtime. The staff was also directed to monitor the potential side effects of the antidepressant and to document every shift. Behavior documentation, which included depression, sad, crying, tearfulness, withdrawn, and mood changes, were to be documented on every shift. Strict intake and output every shift related to urinary tract infection was to be completed. Documentation was reviewed on the medication administration record, the treatment administration record and the nurses notes for November and December 2014. The medication and treatment record directed staff to monitor blood sugars four times daily. The documentation revealed blood sugars were being documented on three times a day with actual numbers. However, for bedtime there was only a check mark, no numbers and no indication as to what time the blood sugar was completed. The treatment record indicated to monitor hours of sleep every shift. However the treatment record for December had check marks and no actual number of hours of sleep. The November and December every shift intake and output record indicated no output documented. On 12/11/2014, at 2:45 p.m. registered nurse (RN)-A was interviewed and indicated staff should document the actual number of hours of sleep not just the check mark. RN-A was unable to locate any more sleep numbers. Output record amounts could not be located. Side effect/behavior monitoring for every shift should be on the medication/treatment record and if not should be in the nurses notes. RN-A could not locate any further information.	F 329		

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F 329	Continued From page 48 On 12/11/2014, at 2:58 p.m., the administrator and director of nursing (DON) were interviewed. Both confirmed, if the the physician orders directed staff to monitor side effect/behavior, intake and output, blood sugars, and sleep hours, the staff would be expected to document that. When interviewed on 12/11/2014, at 3:30 p.m., DON reported there was a computer problem and the blood sugar levels were not identified. She also indicated the blood sugar time should be entered. Policy and procedures were requested however the only policy and procedure provided was Intake and Output Measurement, dated 2006. The policy and procedure directed staff to, instruct resident to urinate in the bedpan, urinal, or collection graduate in toilet and measure and record the amount on the record. The facility failed to monitor hours of sleep and develop individualized non-drug interventions to promote sleep for R82. Review of R82's medical record revealed R82 was admitted on 6/23/14, with diagnoses including dementia and depression. Medications included Trazodone 50 mg: give 1 tab at bedtime for sleeplessness. Physician orders dated 12/4/14, directed staff to monitor number of hours slept every shift. Review of nurses notes, medication and treatment record and care plan did not include	F 329		

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F 329	Continued From page 49 interventions developed or attempted to assist R82 to sleep or monitoring of R82's hours of sleep. Interview with registered nurse (RN)-B, on 12/11/14, at 3:00 p.m., indicated R82 received medication for sleep. Staff should monitor hours of sleep and non-drug interventions to assist with sleeplessness should be developed and monitored for effectiveness.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by:	F 353		1/21/15

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F 353	Continued From page 50 Based on observation, interview and document review, the facility failed to provide staffing in sufficient numbers to meet the needs of 11 of 30 residents who were reviewed (R42, R9, R61, R73, R55, R66, R22, R36, R27, R33 and R72). Findings include: During interviews residents and family complained of not enough staff to meet resident needs. On 12/8/14, at 6:39 p.m., R42 indicated sometimes staff did not answer call lights. R42 was unsure of the length of time waited for staff assistance after putting the call light on. R9 was interviewed on 12/8/14 at 5:40 p.m. and revealed the food was not always hot, but stated, "I just eat it anyway." R9, indicated sometimes it took an hour for the call light to be answered. R9 reported accidents had happened while waiting for staff to help and felt, "pretty down hearted" about it. R61 interviewed 12/8/14, at 7:12 p.m. indicated food on room trays was cold. R61 also reported having waited approximately a half hour for help after putting the call light on. R61 stated, "I have wet myself and felt horrible about it." On 12/8/14, at 4:47 p.m., R73 reported having had to wet the bed two times waiting for help. R73 indicated wait times to get help after putting the call light on were sometimes one and a half hours long. Wait times on the day shift and on the past weekend were particularly long. On 12/8/14, at 1:00 p.m. R55 expressed concern	F 353	Staffing concerns were addressed at resident council meeting on December 24th. Facility reorganized the function of each unit by assigning residents on units into individual nursing assistant assignments to ensure accountability for resident needs being met. Facility will continue to monitor staffing needs based on census and acuity levels with input from staff. Staff will be educated on new procedure. Management team will conduct 5 interviews a week for a month then 3 interviews a week for 2 months with residents and/or family members to ensure needs of residents are being met. Audits will be reviewed by QA to ensure compliance.	

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there were not enough staff because her coffee and food often come cold. If she sent the coffee and food back to be re-heated, there was such a long wait, that often R55 would not ask for re-heating.

R62 was interviewed on 12/8/14, at 6:00 p.m. and expressed concern about the staffing because of having to wait for longer than every two hours for positioning. R62 had a Stage 4 healing pressure ulcer on the coccyx. (Stage IV Pressure Ulcer - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.)

When interviewed on 12/9/14, at 11:00 a.m. R22 expressed concern about the staffing levels at the facility. Although R22 said he was "pretty independent once I'm up in the chair, but I still require assistance and will have to wait and then I just go out and get the staff." R22 found it very frustrating to have to wait long periods from thirty minutes to an hour sometimes.

During interview on 12/09/2014, at 12:46 p.m. R36 stated he felt there was not always enough staff in the facility to meet resident needs. R36 explained that he often had to wait a long time for help at night and on weekends.

A family member of R27, (F)-A, contacted the surveyors regarding concerns. F-A was interviewed on 12/11/14, at 10:45 a.m. F-A indicated R27 would not complain so F-A wanted to bring forth the issues. F-A reported food was not always hot when delivered. F-A also indicated, with the new administration, staffing and the quality of the nursing assistants hired were not

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consistent. "That's where things break down." F-A indicated the facility was short staffed. F-A saw call lights go on and not answered and other families had complained. F-A knew of two family members who recently moved their loved ones out due to not being satisfied with the care. F-A also indicated the facility had some very good aides, but they could only do so much when the facility didn't have enough help.

Observations confirmed the facility failed to provide care according to resident care plans.

R62's active diagnoses from the MDS included paraplegia, diabetes mellitus, cervical spinal stenosis and a Stage 4 pressure ulcer to coccyx present at admission on 12/18/13.

R62's care plan dated 6/10/14, directed staff, "Check and change Q [every] 2 hrs [hours]and prn [whenever necessary] " and "Turn/reposition/off load Q [every] 2 hrs [hours]and prn [whenever necessary]. R62 was cognitively intact according to the Minimum Data Set (MDS) completed 11/25/14.

During observations on 12/8/14, from 4:45 p.m. until 7:30 p.m., R62 remained lying on her back in bed for two hours and forty-five minutes without a incontinence check or position change. During continuous observations on 12/10/14, from 7:15 a.m. until 10:00 a.m., R62 remained lying on her back in bed for two hours and forty-five minutes without an incontinence check or position change. R62's skin, after waiting two hours and forty five minutes for a incontinence check on 12/10/14 at 10:00 a.m., revealed bright red areas with crevices and craters on the buttocks and posterior thighs where there had been wrinkling

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of the incontinence brief and clothing. R62 was incontinent a large bowel movement and urine. Nursing assistants, (NA)-A and (NA)-B verified the condition of the resident's skin at the time of the observation.

R33 did not have a incontinence check and change or position change for three hours and fifteen minutes.

R33's care plan dated 8/22/12, directed staff "Assist of 1 to turn and reposition Q 2 hrs while in bed or w/c [wheel chair]. 1 assist to check brief Q 2hrs and change PRN. " R33 was severely cognitively impaired due to diagnosis of Alzheimer's disease, according to the MDS completed 4/28/14.

During continuous observations on 12/10/14, from 7:15 a.m. until 10:27 a.m. R33 remained seated in the wheel chair for three hours and fifteen minutes without a incontinence check and change or position change.

R33 was assisted to bed by NA-A, NA-B and the use of a mechanical lift on 12/10/14, at 10:27 a.m.. R33 was incontinent a large amount of loose bowel movement that was up to R33's lumbar area of the back and incontinent a large amount of urine, as the brief was completely saturated. R33's skin was bright red with crevices and craters on the buttocks and posterior thighs where there had been wrinkling of the incontinence brief and clothing. NA-A and NA-B verified the condition of the R33's skin at the time of the observation.

R72 was incontinent of urine, at risk for urinary tract infection and required assistance with

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incontinence care every two hours.

Review of the plan of care dated, 1/18/14, directed staff for toileting with alteration in elimination requiring the Check and Change Program every 2 hours for incontinence.

R72's cognition was impaired according to the form titled, Brief Interview for Mental Status (BIMS) dated, 1/31/14. R72 had a diagnosis of Dementia and was receiving hospice services.

During numerous observations on 12/08/14, and 12/10/14, from 8:00 a.m. until 10:22 a.m., R72 was not checked for incontinence and did not receive incontinence care. Observation on 12/10/14, at 10:22 a.m., revealed R72 was incontinent a moderate amount of urine. Interviews with staff revealed concerns with staffing levels being insufficient to meet the needs of residents.

On 12/10/14, at 11:00 a.m. interviews with the nursing staff regarding the lack of timely positioning observations for R33, R62, and R72, revealed a general consensus that there was not enough staff to provide residents care in a timely fashion. A licensed practical nurse, (LPN)-A, NA-A, NA-B and NA-C expressed frustration with being unable to get all the work done for the residents. RN-A validated the staffing concerns, and when questioned, revealed there were ten of twenty-five residents who were incontinent of urine and required an every two hour check and change and positioning. There were three residents in the dying process. There were eleven residents who needed a mechanical lift to re-position every two hours. Use of the mechanical lifts required two staff members be

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F 353	Continued From page 55 present for the transfer of a resident. On 12/10/2014 at 10:25 a.m., nursing assistant (NA)-F indicated nursing assistants cannot get documentation done because insufficient time. Nursing assistants did not get breaks most of the time. Nursing assistants were unable to walk residents as needed and residents did not always get turned and toileted on time because of insufficient time. During an interview on 12/10/2014, at 12:34 p.m., LPN-A explained there were no permanent assignments and staff were required to look at the reference guide on the computer to know each residents' needs. Even pool staff had to look up each resident to review the individual care needs. When interviewed on 12/10/14, at 10:10 a.m. a licensed practical nurse (LPN)-B and registered nurse (RN)-C were asked if they thought staffing was sufficient in the facility. They replied that it depended on the census and the acuity of resident care. RN-C explained that if there was an admission, an emergency, or resident acuity was high, providing adequate care would be difficult. LPN-B reported there were times when two nurses would be useful on the unit with transitional care residents. LPN-B stated that she had never known staffing to change due to staff verbalizing a request for more staff. On 12/11/14, at 2:30 p.m. NA-B and NA-C were interviewed and indicated when there were only two nursing assistants, staff could not get the work done as easily and charting did not get done.	F 353		

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Interview with nursing assistant (NA) -D on 12/12/14, at 9:50 a.m., revealed she is "not able to get all the residents out of bed and into the dining room for breakfast by 8:15 a.m." She reported a couple of residents eat breakfast in their room, as she did not have time to get them dressed in the morning. The staffing on the 300 wing was one nursing assistant and one nurse or trained medication aide (TMA). NA-D reported the nurse would help as able, but had to get all of their own work done.

The 300 wing was the secured unit and most residents were not able to be accurately interviewed regarding how much staff assistance they need.

The staffing schedules were reviewed from 11/21/14 thru 12/7/14. The census for the 2 weeks was between 58-60 residents. Generally the staffing pattern was 2 nursing assistants (NA's) for days and evenings on the 100 wing, which was transitional care unit (TCU) and long term care (LTC). On the day of entrance the census on the 100 wing was 20 residents. On the 200 wing, which was LTC. Generally there were anywhere from two to four nursing assistants on the day and evening shift. On the day of entrance there were 25 residents on the 200 wing. The 300 wing, which was the secure unit, had 12 residents on the day of admission and was staffed on all shifts with one nursing assistant and one nurse. There was one nurse on the 100 and 200 wings for days and evenings.

On 11/24/14 on the day shift 200 wing there were two nursing assistants and one did not arrive until 8 a.m. leaving one nursing assistant working

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F 353	Continued From page 57 alone from 6-8 a.m. On 11/27/14 on the day shift, 200 wing there were only two nursing assistants on the day shift. On 11/30/14 on the day shift one nursing assistant was on the 200 wing who worked from 6-10 am leaving two nursing assistants until 2 p.m. On 12/3/14 on the day shift 200 wing/100 wing one person called in who was to float between 100/200. This left two nursing assistants on 100 wing which is TCU/LTC and three nursing assistants on the 200 wing which was LTC. On 12/4/14 on the day shift the float person between 100/200 called in again leaving two nursing assistants on the 100 wing and three nursing assistants on the 200. On the evening shift there were only two nursing assistants on the 100 wing and two nursing assistants on the 200 wing. On 12/5/14 evening shift on the 200 wing had only two nursing assistants. On 12/7/14 on the day shift 200 wing only two nursing assistants were scheduled. When interviewed on 12/9/14, at 4:00 p.m., the director of nursing (DON) and administrator indicated they staffed according to the number of residents and the acuity. They also staffed according to what the staff said were their needs. Generally the facility was staffed with five to six aides. There were no permanent assignments and all staff were expected to help one another. A staffing policy and procedure was requested, however, none was provided.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		1/21/15

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F 356	Continued From page 58 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to display the actual hours worked for all nursing staff on the daily staff posting. This had the potential to affect all 58 residents, staff, and any visitors who may wish to review this information.	F 356	Facility had been posting total nursing hours per position per shift according to state regulation. Facility form has been updated to include exact shift times.	

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F 356	Continued From page 59 Findings include: During initial tour of the facility, on 12/8/14, at 12:10 p.m., the daily staff posting was observed posted on the window ledge near the front entrance of the facility. The posting did not identify the actual hours worked for each shift and each classification of staff. During interview, on 12/12/14, at 10:20 p.m., the administrator indicated the staffing coordinator filled out the form. The administrator verified the form did not identify the actual hours worked by each classification of staff. A policy for the posting the staffing was requested and not received.	F 356		
F 361 SS=E	483.35(a) QUALIFIED DIETITIAN - DIRECTOR OF FOOD SVCS The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis. If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian. A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.	F 361		1/21/15

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F 361	Continued From page 60 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide necessary services of a qualified dietician regarding assessment, planning, and implementation of care for 4 or 4 residents (R25, R31, R77, R95) reviewed for nutrition. Findings include: R25 experienced significant weight loss, was not assessed by the facility's registered dietician, was not weighed consistently, did not receive high nutritional risk monitoring, and had a physician's order for a calorie count that was not completed timely and accurately. Review of the admission record revealed R25 was admitted on 6/25/14, with diagnoses including anemia, diabetes II with neurological manifestations, hypothyroidism, malaise, fatigue, vascular disease, kidney disease, and pressure ulcer. R25 was discharged on 9/27/14. The Weights and Vitals Summary form in the record indicated R25 weighed 264.6 lbs. (pounds) on 6/25/14. By 7/4/14 this R25's weight was 239.6 lbs. The lowest weight for R25 was recorded on 7/26/14 at 232.8 lbs.--a weight loss of more than 10% since admission. Six Dietary-Nutrition assessment forms were completed on R25, dated 7/2/14, 7/18/14, 7/23/14, 8/20/14, 8/21/14, and 9/19/14. All of these assessments were completed by the facility's certified dietary manager. No assessment completed by the facility's registered dietician was found in the record. According to	F 361	Resident R25, R31, R77 have discharged from facility. Resident R95 was assessed by Registered Dietician on 12/11/14. Facility Registered Dietician will visit facility weekly and maintain a monthly review for all residents that are nutritionally at high risk. Any resident determined to be at high nutritional risk will be assessed and put on a list. Assessments will continue quarterly and annually until nutritionally stable. Dietary Manager will audit the list of resident at high nutritional risk for completion of nutritional assessments weekly for a period of three months. All audits will be reviewed at QA to ensure compliance.	

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F 361	Continued From page 61 the completed Dietary-Nutrition assessments, R25 should have been weighed daily and was on a controlled carbohydrate diet, until the 9/17/14 when the diet was changed to a regular diet, but daily weights continued. Many dates of daily weights were not present on the Weights and Vitals Summary form for R25. There was not documentation in the record that R25 had refused being weighed. The record also contained a physician's order, dated 8/21/14, that read, "Calorie count x 1 week, then update MD." The documentation of this calorie count could not be located in the record. On 12/11/14 the surveyor asked the facility administrator if there was another location where this calorie count could be documented and was provided with a copy of a Food Intake Record, dated 8/25/14, 8/26/14, and 8/27/14, showing what R25 ate on those days, but no calorie calculations. The administrator also provided a copy of an email, dated 12/11/14, from the facility's registered dietician that read, " You only sent me 3 days for the calorie count and I didn't realize that you wanted me to calculate it for you until today...This is my best estimate since I don't know exactly what foods he received at his meals, but he ate way over 1800 kcals [calories] on 8/25 and 8/26..." When interviewed on 12/11/14, at 11 a.m. the facility's registered dietician reported she reviewed the diet of R25 when she visited this facility in September and made a note, but did not document that note in R25's record. When asked by the surveyor where this note may have been documented, the registered dietician replied she thought she may have left it on a report for the certified dietary manager at the facility.	F 361		

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When interviewed on 12/11/14, at 3:30 p.m. the facility administrator reported the staff at the facility were not aware of such a report and could not locate it.

R31 experienced significant weight loss, was not weighed consistently, was not assessed by the facility's registered dietician, and did not receive high nutritional risk monitoring.

Review of the admission record revealed R31 was admitted on 7/28/14, with diagnoses including aftercare for healing traumatic fracture of hip, pneumonia, and pressure ulcer. R31 was discharged on 9/17/14.

The Weights and Vitals Summary form in the record indicated R31 weighed 129 lbs. on 7/29/14. By 8/9/14 R31's weight was down to 110.4 lbs.--a weight loss of more than 10% since admission. This form indicated R31 was weighed seven times during her stay at the facility, weights were not taken every week on this resident, and R31's last weight before discharge was 112.9 lbs. on 9/12/14. There was not documentation in the record indicating R31 had refused being weighed.

Two Dietary-Nutrition assessment forms were completed on R31, dated 8/4/14 and 8/25/14. Both these assessments were done by the facility's certified dietary manager. No assessment done by the facility's registered dietician was found in the record. According to the completed Dietary-Nutrition assessments, the resident was on a mechanical soft diet, used a right curved spoon, and needed set up and assist with meals. The 8/25/14 assessment read that

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R31's weight was 111.4 lbs., BMI (body mass index) was 17.8, and her ideal body weight was 130 lbs. (The Center for Disease Control and Prevention website revealed that a BMI less than 18.5 for an adult is categorized as underweight.) This assessment also read R31 had a new order for a nutritional supplement twice daily.

When interviewed on 12/11/14, at 11:06 a.m. the facility's registered dietician reported she had no notes on R31 and the facility staff had never communicated anything to her regarding R31.

R77 received tube feedings and experienced weight loss, did not receive high nutritional risk monitoring, and had a physician's order for a calorie count that was not completed timely.

Review of the admission record revealed R77 was admitted on 9/26/14, with diagnoses including aftercare for healing of traumatic fracture of hip, adult failure to thrive, pressure ulcer, eating disorder, unspecified protein-calorie malnutrition, nausea, iron deficiency anemia, and irritable bowel syndrome. R77 remained in the facility.

The Weights and Vitals Summary form in the record showed that R77 weighed 111.2 lbs. on 9/30/14. By 10/16/14 R77's weight was down to 95.4 lbs--a weight loss of more than 10% since admission. The most recent weight recorded was 101.6 lbs. on 12/11/14.

Four Dietary-Nutrition assessment forms were completed on R77, dated 10/8/14, 10/27/14, 11/24/14, and 12/10/14. Three of these assessments were done by the facility's certified

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dietary manager. One assessment was done by the facility's registered dietician, dated 10/8/14. The registered dietician's assessment, dated 10/8/14, showed that R77 was at 86% of ideal body weight, with a BMI of 18.0, and weight gain was desirable. This assessment also contained calculations of calorie, protein, and fluids requirements for R77, along with calculations for tube feedings. The registered dietician's assessment listed the resident's diagnoses (including anorexia), medications that could affect nutritional status, intake patterns, some lab results, the use of a nutritional supplement, and the fact that R77 had a nasal gastric tube placed on 9/24/14 for tube feedings. When referring to R77's intake in this assessment, the registered dietician wrote, "Limited food records." The summaries in the assessments done by the certified dietary manager on 10/27/14, 11/24/14, and 12/10/14 were brief, including the resident's weight, order for daily weights, order for regular diet as tolerated, the fact that the resident made her needs known, the resident wanted mashed potatoes and gravy for lunch and supper each day, and R77's general intake of meals and liquid nutritional supplement. There was no documentation in the record of monitoring of this resident's condition by the registered dietician.

The record also contained a physician's order, dated 12/4/14, that read, "Dietary to review to make sure she is getting enough calories." The documentation of the calculation of this calorie count could not be located in the record. On 12/11/14 the surveyor asked the facility's certified dietary manager and administrator if there was another location where this calorie count could be documented and was provided with a copies of three Calorie Count Tracking forms, dated

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12/4/14, 12/5/14, and 12/6/14, showing what R77 ate on those days, but no calorie calculations, and an undated, unsigned, copy of a piece of notebook paper that showed the calculations of calories and protein for those dates. At that time, the certified dietary manager stated that the calculations had not been completed before the surveyor requested them.

R95 experienced significant weight loss, weekly weights not done consistently, and was not on high nutritional risk monitoring.

Review of the admission record revealed R95 was admitted on 9/18/14, with diagnoses including hemiplegia affecting his dominant side, anorexia, kidney disease, and esophagitis. R95 remained in the facility.

The Weights and Vitals Summary form in the record showed that R95 weighed 180.2 lbs. on 9/19/14. By 10/19/14 R95's weight was down to 150.2 lbs.--a weight loss of more than 10% since admission. The most recent weight recorded was 155.6 lbs. on 12/5/14. There were significant gaps between documented weights in the record--a weight on 9/23/14, then none until 10/19/14; a weight on 10/22/14, then weights only on 11/14/14 and 12/05/14. There was no documentation in the record of R95 refusing weights.

Five Dietary-Nutrition assessment forms were completed on this resident, dated 9/15/14, 9/30/14, 10/17/14, 11/14/14, and 12/5/14. All these assessments were done by the facility's certified dietary manager. No assessment done by the facility's registered dietician was found in

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the record. According to the completed Dietary-Nutrition assessments, R95 was on a regular diet. The 11/24/14 assessment read that a nutritional supplement three times daily had been added to R95"s nutritional plan of care on 10/19/14.

During interview on 12/11/14, at 10:50 a.m. The facility's registered dietician reported she had not assessed R95. Nobody at the facility informed her of any problems with him. The registered dietician reported the certified dietary manager at this facility generally did the nutritional assessments. She explained that the registered dietician did assessments for tube feeding residents, calorie count calculations, and assessments on residents who had nutritional issues. The registered dietician reported she does not maintain a list of residents at high nutritional risk and the facility did not have a high nutritional risk process. She explained she is a part-time worker and she did not believe providing high risk nutritional assessment and monitoring was part of her job. She reported she only visited the facility in January, February, July, September, and October in 2014. She went on to explain that another dietician had previously been employed by the facility who did the high nutritional risk monitoring and that dietician no longer worked at the facility. She was asked by the surveyor if a lack of high nutritional risk assessment and monitoring at the facility concerned her. She replied that it did concern her and she had shared those concerns with the administration of the facility and asked the administration for more registered dietician services. She indicated she did not have a plan for her next visit to the facility and she was unsure when that might be due to her limited

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F 361	Continued From page 67 work hours. When interviewed on 12/11/14 at 12 p.m., the facility administrator was asked if she was aware that the facility registered dietician did not provide high nutritional risk assessment and monitoring of residents for the facility and that the registered dietician had not visited the facility since October 2014. The administrator reported the registered dietician should visit this facility 1-2 times monthly, at least monthly, and should provide all the professional services of a registered dietician to the facility. The administrator also reported she was not aware that the registered dietician was not providing all the necessary professional services and had not been at the facility since October. Page 55 of the facility's undated Residents at Nutritional Risk policy read, "...Residents at risk for developing nutrition-related problems or medical/physicial [sic] problems as a result of poor nutritional status will be monitored. Food and fluid intake will be monitored as a critical element in the evaluation process...1. Residents with any of the following conditions should be considered at nutritional risk: a. Significant unplanned weight loss (5% in 30 days, 10% in 180 days)...c. Intake, less than 75% at 2 meals or more/day for 4 out of 7 days/week...f. Physical or behavioral inability to feed self g. Tube feeding h. Pressure ulcer - Stage 1-4, stasis ulcer, open wound i. Chronic vomiting/diarrhea or diagnosis of malabsorption j. Eliminates one or more of the four food groups...m. Diagnosis of malnutrition or abnormal lab values indicating malnutrition (i.e. albumin)...q. Failure to eat due to mood changes... 2. Resident names will be placed on the charting record when they meet any one of	F 361		

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F 361	Continued From page 68 the above criteria. Their names will be removed when they are no longer at nutritional risk. a. Names can be added or deleted by the Consultant Dietitian or Dietary Department Head. b. Addition to the list can be made at the quarterly care conference, visits by the Consultant Dietician or when a significant change in condition occurs. c. The Consultant Dietitian will review and update this quarterly in the medical record and document progress..." The facility's job description for a clinical dietician, dated December 2013, read, "Essential Functions...17. Review the dietary requirements of each resident admitted to the facility, as may be required, and assist the attending physician in planning fro the resident's prescribed diet plan. 18. Ensure that all progress noted [sic] charted are informative and descriptive of the services provided and of the resident's response to the service. 19. Plan normal and special diet menus as prescribed by the attending physician. 20. Participate in discharge planning, development and implementation of resident care plans, resident assessments, etc. as required. 21. Involve the resident and family in planning objectives and goals for the resident...25. Visits residents routinely to evaluate the excellence of meals served, likes, and dislikes, etc..."	F 361		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		1/21/15

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F 364	Continued From page 69 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide food at temperatures that enhanced the palatability of the food for 9 of 22 residents interviewed (R9, R61, R55, R27, R62, R98, R36, R27 and R32). Findings include: Review of the council minutes for September 24, 2014, attended by 8 unnamed residents indicated a concern with cold food brought forth. The October 22, 2014 meeting attended by 10 unnamed residents indicated dietary was trying to use insulated basins and covers on room trays to keep them warmer. R9 was interviewed on 12/8/14, at 5:40 p.m. and revealed the food was not always hot, but R9 said "I just eat it anyway." On 12/10/2014 at 1:20 p.m., when asked about lunch, R9 said, "the the food was no good. The meat loaf was cold." When asked about reheating, R9 said, "they did, but it was still cold." On 12/8/14, at 7:12 p.m. R61 reported if she at in her room, which happened most of the time, the food was cold. R61 did not ask for reheating of the food. When interviewed on 12/8/14, at 1:00 p.m. R55 had the meal tray in the room and expressed dissatisfaction and stated, "The food is always cold." Observation of the meal tray revealed a metal type cover on the food plate which did not	F 364	Food Temperatures was addressed at Resident Council on 12/24/14. Facility obtained a multi-compartment heated tray cart to transport room trays and ensure proper temperatures. Policy and Procedure was reviewed and updated for new process. Staff will be educated on updated policy. Dietary manager will audit food temperatures on room trays three times a week for three months on various meal times. All audits will be reviewed at QA to ensure compliance.	

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F 364	Continued From page 70 have the capacity to hold heat. When interviewed on 12/8/14, at 4:14 p.m. R27 expressed the food could be hotter and the staff have been told many times. R27 expressed the feeling of "just accepting the situation." R27 preferred not to send the food back for reheating because it took longer then to get the food back. During an interview with R62 on 12/8/14, at 5:07 p.m. the concern about food being cold was addressed. R62 received a room tray for all three meals and expressed frustration because the majority of the time the food arrived cold, especially the eggs every morning. Observation of the breakfast tray on 12/10/14, at 8:11 a.m. was delivered with a Turnbury cover which was suppose to help retain heat. R62 stated the eggs were still cold and expressed frustration that it happened all the time. During interview on 12/09/2014, at 10:07 a.m. R98 stated that the food served at the facility was often cold. During interview on 12/09/2014, at 01:39 p.m. R36 stated that the food served at the facility was often cold, especially eggs at breakfast. R36 explained the facility staff would re-warm the food if asked, but he often just ate the cold food because he was hungry and did not want to wait. R45 was interviewed on 12/10/14, at 8:46 a.m. and talked about being in the restaurant business for many years and knew how important it was to keep food hot and between certain temperatures. R45 reported the facility was aware of the cold food situation, but they had not taken care of the cold food issues yet.	F 364		

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A family member of R27, (F)-A was interviewed on 12/11/14, at 10:45 a.m. F-A indicated R27 would not complain so F-A wanted to bring forth the issues. One of the concerns voiced was the food was not always hot when delivered.

On 12/12/2014, at 9:40 a.m., an active council member, R32, confirmed residents at resident council had informed the facility of concerns regarding cold food.

Interview with the dietary manager (DM) on 12/10/14, at noon, indicated she had not attended the last two resident council meetings. She reported she had heard that some of the residents complained about cold food, but nothing specific.

Observation of the evening meal on 12/8/14, at 4:55 p.m. revealed room trays were taken on a metal open push cart without the beverages covered. R32 had coffee, which was poured and left uncovered as it was wheeled down to his room.

On 12/9/14, at 8:00 a.m. 4 room trays were observed brought out on a cart for R88, R32, R55, R62. All had the entree with 3 trays having insulated covers and one a regular metal cover. All of the juices and coffees were taken down the hall without covers. There were 2 more random observations of trays being brought out of the dining room with juice and coffee not covered.

A nursing assistant, (NA)-B was interviewed on 12/10/14, at 8:14 a.m., and indicated the liquids were supposed to be covered. NA-B confirmed they had not been covered. NA-F was

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interviewed on 12/10/2014, at 8:34 a.m., and agreed all liquids needed to be covered. NA-F indicated the liquids had not been covered.

The policy and procedure, Serving Food, dated 6/2005, directed nursing staff to completely cover food items if transporting down the hallway.

On 12/11/14, a test tray was prepared at breakfast . At 8:04 a.m., a tray containing cereal and eggs over hard was prepared. The staff put the tray on a cart, and then went across the hall and put beverages on the trays, and then went down the 100 hallway. At 8:10 a.m. the test tray temperatures were checked with the DM. The cereal was 138F (degrees Fahrenheit) and the eggs were 112 F. Interview with the DM revealed the plates were not warmed, but were set in a Dynex base and covered with a Dynex Dome. At 8:20 a.m. the DM reported she thought she used a thermometer which was not calibrated.

A copy of the manufacturers recommendations for the Dynex dome and base were requested and received on 12/11/14, at 8:20 a.m. The information directed the following: 30 minute meal delivery base. No heating required with foam-insulated base. Place heated plate on base, cover with insulated dome

On 12/11/14, at 12:00 p.m., a test tray was prepared and the staff took the plate (with a Dynex base and dome) and put it on a tray that already had beverages on it and took it down the 200 wing. At 12:10 p.m. the last tray was served to a patient, and the test tray temperatures were checked by the DM. The chicken was 128 F, the cauliflower was 110 F, the french fries

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F 364	Continued From page 73 temperature was not checked, but the DM touched them and indicated the french fries were cool to touch. The DM verified the plates were cool when the dining service started and the food temperatures were a problem. On 12/10/2014, at 8:36 a.m., the therapeutic recreation director (TR), who facilitated the resident council, was interviewed about food concerns. TR indicated dietary staff attended the meetings so the TR assumed dietary staff were taking care of the concerns of cold food. The policy and procedure, Serving Food, dated 6/2005, directed staff to make sure hot foods were hot and cold foods were cold.	F 364		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review the pharmacist failed to advise the facility regarding behavior/side effect monitoring for 1 of 5 residents (R73) whose medications were reviewed and failed to advise the facility on the	F 428	R73 had behavioral/side effect monitoring added to her MAR. All residents on antidepressants were reviewed to ensure behavioral/side effect monitoring was on MAR.	1/21/15

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F 428	Continued From page 74 use of non-pharmacological interventions for sleep for 1 of 3 residents (R82) who was receiving a sleep medication. Findings include: Physician orders for R73 directed the staff to do behavior documentation which included depression, sad, crying, tearfulness, withdrawn, and mood changes. Documention was to be completed every shift along with side effect monitoring. Review of the pharmacy notes for R73, from admission on 7/1/14 through 12/3/14, did not reveal any requests from the pharmacist regarding behavior monitoring/side effect monitoring as requested from the physician. These notes of 8/1/14 indicated Celexa 20 mg (milligrams) every day. The facility pharmacist was interviewed, on 12/12/14 at 3:45 p.m., and indicated the staff should be monitoring behavior/side effects. The consultant pharmacist had not recommended this to the staff. R82 received a medication for sleep, and non-pharmacological interventions were not attempted in order to decrease the medication use. R82's current physician orders, dated 12/11/14, included an order for Trazodone (an anti-depressant) 50 milligrams (mg) at bedtime for sleeplessness. May repeat if not effective in one hour. The December 2014 medication administration record (MAR) showed R82 received the medication daily, and contained	F 428	F82 had non-pharmalogical interventions for sleep added to her MAR. All residents on antidepressants for sleep were reviewed to endure non-pharmalogical interventions for sleep was on MAR. Consultant Pharmacist will audit all new antidepressant orders monthly for three months for behavioral/side effect monitoring and non-pharmalogical interventions. All audits will be reviewed by QA to ensure compliance.	

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F 428	Continued From page 75 monitoring for side effects of the anti-depressant use, but contained no documentation of any non-pharmacological intervention used related to R82's sleeplessness. Interview with the consultant pharmacist on 12/12/14 at 3:45 p.m., verified that non-pharmacological interventions should be tried in order to possibly reduce the medication use. He indicated he had not recommended this to the staff.	F 428		

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Angels Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/09/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2014**

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ANGELS CARE CENTER	**300 NORTH DOW STREET** **CANNON FALLS, MN 55009**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility will be surveyed as two separate buildings. Angels Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1977 and was determined to be of Type II(111) construction. In 1982, addition was constructed to the West Wing that was determined to be of Type II(111) construction. In 1985, another addition was added to the South Wing and was determined to be Type II (111). The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 73 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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	245304	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2014**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 5 out 58 residents. Findings include: On facility tour between 11:30 AM and 2:00 PM on 12/12/2014, observation revealed, that the boiler room door will not shut/latch. This deficient practice was confirmed by the Administrator (KU) at the time of discovery.	K 029	The boiler room door has been adjusted by the maintenance director and is currently working properly with the door closer. Maintenance Director surveyed the entire building to ensure all automatic door closers are working properly. Maintenance Director or designee will audit all automatic door closers weekly for one month then monthly for two months to ensure proper clearance is maintained. Audits will be reported to QA committee.	1/21/15
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		1/21/15

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K 144	Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 58 residents. Findings include: On facility tour between 11:30 AM and 2:00 PM on 12/12/2014, documentation review of the weekly inspection logs for the emergency generator revealed, that the emergency generator weekly inspection logs from 12/20/13 to 12/08/14, indicated that the week of 11/10/14 was missed. This deficient practice was confirmed by the Administrator (KU) at the time of discovery.	K 144	The Maintenance Director was on vacation the week of 11/10/14. He is the only maintenance staff for the facility. Facility procedure is changed to have maintenance director assign lead housekeeper or designee to complete the weekly generator inspection in his absence.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		1/21/15

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K 147	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70, 110-26. The deficient practice could affect 5 out of 58 residents. Findings include: On facility tour between 11:30 AM and 2:00 PM on 12/12/2014, observation revealed, that in the PT/OT room #100, the circuit breaker panel does not have proper clearance. NOTE: Check the entire facility for this deficiency This deficient practice was confirmed by the Administrator (KU) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	Equipment was rearranged in the Therapy room #100 to ensure proper clearance of the circuit breaker. Maintenance Director surveyed the entire building to ensure all circuit breakers had proper clearance. Maintenance Director or designee will audit all circuit breakers weekly for one month then monthly for two months to ensure proper clearance is maintained. Audits will be reported to QA committee.	

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	245304	A. BUILDING **02 - 2007 CHAPEL ADDITION** B. WING _____	**12/12/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Angels Care Center was found 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 18 New Health Care. This facility was surveyed as two separate buildings. The Angels Care Center, 2007 addition is a 1-story building, with no basement. The 2007 addition was determined to be of Type V(111) construction. The 2007 addition is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 73 beds and had a census of 58 at time of the survey. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 000	EPOC	

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

Electronically Signed | 01/09/2015

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