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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DRT3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00429

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245349**

2.STATE VENDOR OR MEDICAID NO.
(L2) **334740100**

3. NAME AND ADDRESS OF FACILITY
(L3) **STEWARTVILLE CARE CENTER**
(L4) **120 FOURTH STREET NORTHEAST**
(L5) **STEWARTVILLE, MN** (L6) **55976**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/5/2018** (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)
04/30

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

12.Total Facility Beds **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(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 :
Jennifer Kolsrud, HFE NE II 09/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 09/18/2018 (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
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245349

September 18, 2018

Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

Dear Administrator:

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 August 31, 2018 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered

September 18, 2018

Stewartville Care Center
Attn: Administrator
120 Fourth Street Northeast
Stewartville, MN 55976

RE: Project Number S5349029

Dear Administrator:

On August 10, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 15, 2018. (42 CFR 488.422)

- Civil money penalty (42 CFR 488.430 through 488.444)

- Discretionary Denial of payment for new Medicare and Medicaid admissions effective October 8, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on July 20, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 11, 2018, the Minnesota Department of Health and Public Safety completed Post Certification Revisits (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 31, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2018, as of August 31, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 31, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter from August 10, 2018:

- Per instance civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 8, 2018 be rescinded as of August 31, 2018. (42 CFR 488.417 (b))

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DRT3

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(L5) **STEWARTVILLE, MN** (L6) **55976**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/20/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Vicky Hamersma, HFE NE II 08/27/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Sr. Health Program Rep 09/08/2018 (L20)

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

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____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :
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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)
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

August 10, 2018

Mr. Eugene Gustason, Administrator
Stewartville Care Center
120 Fourth Street Northeast
Stewartville, MN 55976

RE: Project Number S5349029

Dear Mr. Gustason:

On July 20, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby 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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

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

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

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

- State Monitoring effective August 15, 2018. (42 CFR 488.422)

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

- Civil money penalty. (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:

- Discretionary Denial of payment for new Medicare and Medicaid admissions effective October 8, 2018. (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 October 8, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 8, 2018. 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, Stewartville Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 8, 2018. 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 waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial

compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976**

(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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 16, 17, 18, 19 & 20, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On July 16, 17, 18, 19, and 20, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000 GPN 8/22/18		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms,	F 604		8/29/18

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

Electronically Signed | 08/20/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

(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 604	Continued From page 1 consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a monitor floor alarm and seat alarm were not being used as a restraint for 1 of 1 residents (R1) reviewed for psychosocial restraints. Findings include: R1's Face Sheet, printed, 7/19/18, identified diagnoses of weakness, history of falling, and macular degeneration, and an admit date of 4/29/16. R1's Care Plan, revised 4/25/18, indicated R31 is at a greater risk than normal for falls, with an	F 604	Stewartville Care Center staff treat all residents with respect and dignity. The goal is for each resident to attain and maintain his/her highest practicable well-being in an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation as well as freedom from any physical or chemical restraint that is not required to treat the resident□s medical symptoms. The resident□s condition and the need for safety/enabling devices are reviewed at the time of admission and reassessed quarterly and with changes in condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING _____ B. WING _____	07/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 604	Continued From page 2 intervention of a seat alarm in wheelchair. R1's physician's orders dated 7/17/18, indicated seat alarm in chair while in chair and recliner every shift. R1's Alarm Training Form, dated 12/13/17, identified bed and/or chair alarms may be indicated as a diagnostic tool in fall assessment and management. Alarms should be used for determining patterns, trends, identifying patient needs, and establishing a plan of care. Note: Alarms should be used on a short-term basis. Alarms during period do not sound, (R1's name) will turn off, can be impulsive, will use call light but will not wait. Action plan: continue with alarms, contact therapy for evaluation of use of alarms for safety, transfers, and ambulating in room. R1's annual Minimum Data set (MDS) and assessment dated, 7/25/18, revealed intact cognition, needed extensive assist with all activities of daily living and chair alarm was used daily. R1's Nursing assistant (NA) Assignment Sheet, indicated R1 used a seat alarm. During observation and interview on 7/17/18, at 3:34 p.m. R1 is seated in her recliner and there is a rectangular gray mat at the foot of her recliner. R1 stated to this surveyor, "Don't step on my alarm, [R31 was pointing at the rectangular gray alarm on the floor in front of the recliner], it will go off! It wouldn't be so bad but it takes them, forever to come and shut it off." R1 stated, "It makes me feel like I am in prison with that thing going off. Wouldn't you feel that way?" R1 further	F 604	The facility has policies and procedures that ensure the following: "Based on an individualized assessment, there is a medical symptom justifying the use of a positional alarm alerting device (an alerting device will not be used for discipline or staff convenience); "A practitioner□s order for the use of the alarm alerting device will be obtained based upon the identified medical symptom necessitating alarm use; "Interventions have been defined and implemented according to standards of practice for the use of an alarm alerting device; "The least restrictive positional alarm alerting device is used for the least time possible with the goal of not unnecessarily inhibiting a resident□s freedom of movement or activity; "Ongoing monitoring and evaluation of the use of alarm alerting devices; "Interventions are developed and implemented for reducing or eventually discontinuing the use of the alarm alerting device; "The resident/representative will be informed of potential risks and benefits of the alarm alerting device and alternatives to alarm use; and "The resident/representative has a right to refuse the use of a positional alarm alerting device and can withdraw consent for the use of an alarm at any time. During the mandatory meetings August	

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F 604	Continued From page 3 stated, they say I have to have it, it's a federal regulation, and they won't take it away, especially since I just fell the other day. It's supposed to help so I don't fall, but I fell in the bathroom the other day, so what good did that do? During interview on 7/18/18, at 8:02 a.m. R1 stated, I have told the staff over and over, I do not want these alarms, I have bitched about it, but it does no good, they tell me I have to have them for my own safety. At my care conferences, they bring it up and I tell them I don't want them. "These alarms make me feel like I am in prison." During observation on 7/18/18, at 9:34 a.m. R1 is sleeping in her recliner in her room, has gray alarm mat in front of her recliner, call light is within her reach. During interview on 7/19/18, at 9:51 a.m. R1 stated, the floor mat alarm they have me use, I do not like because it will buzz if I bump it and sometimes it takes them awhile to turn it off. I used to have a chair alarm but I think it broke a couple weeks ago, I think they forgot to put it back on and I am happy about that. "If I am going to stand up without help, I know I am probably going to fall, I don't need an alarm to tell me that, I have a call light I can use to ask for help as she points to the call light. R1 continued to say that "I don't need these alarms, and they make me feel like a prisoner." During interview on 7/19/18, at 9:54 a.m. licensed practical nurse (LPN)-B verified R1 is alert and cognition is intact, and uses a floor mat alarm and a chair alarm for her wheelchair and her recliner. LPN-B stated these alarms are in place because R1 self-transfers and is not safe to transfer by	F 604	21, 22 and 23, 2018, the nursing staff will be reinstructed on 1) the definition of a physical restraint 2) the facility□s policies and the procedures for use of positional alarm alerting devices 3) the need for a comprehensive assessment of the risks and benefits of using a positional staff alerting alarm prior to implementation 4) the physical and psychological risks of using an alarm alerting device 5) development a person-centered plan of care to maximize resident safety and reduce the negative effects of positional alarm alerting devices and 6) the use of the least restrictive alarming device with the goal of discontinuing the use of positional alarm devices as soon as possible. The staff will also be informed of the implementation of the new resident/representative consent form that outlines the risks/benefits of alarm use. During the July 24, 2018 care conference for Resident number 1, the use of the staff alerting alarms was reviewed with the resident and family. A waiver was signed by the resident and family acknowledging the risks of the staff not being alerted to unsafe posturing. The resident□s care plan has been updated to reflect discontinuation of alarm use. The resident□s condition will continue to be assessed quarterly and with changes in condition; safety interventions will be reviewed for appropriateness. Compliance will be monitored by the social worker/designee through record review and observation. All residents currently using alarm alerting devices that	

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F 604	Continued From page 4 herself. LPN-B further stated when R1 was first admitted she didn't want the alarms. LPN-B stated, "She didn't want an alarm, because she didn't like the noise." LPN-B explained, the floor alarm is placed on the floor in front of the resident and when pressure is applied the alarm goes off alerting staff that resident is up moving and the chair alarm is placed under resident when she sits in her recliner or her wheelchair, so when pressure is removed the alarm goes off alerting staff the resident is getting up. LPN-B verified the seat alarm was ordered by the doctor on 1/30/18. LPN-B stated, R1 has come around now, and realizes she needs the alarms, I know it's no fun, I wouldn't want to lose my independence either." During interview on 7/19/18, at 10:15 a.m. trained medication aide (TMA)-A verified R1 uses a seat alarm and a floor alarm, has had the alarms for about a year and they are used for safety. TMA-A stated R1 is cognitively intact and knows how to use a call light. TMA-A stated R1 is located at the end of the hall from the nurse's desk and when the alarm goes off it is pretty loud and we are able to hear it at the nurse's station. When TMA-A was queried if R1 liked the alarms being used, TMA-A started laughing and stated "No, do any of them?" During interview on 7/19/18, at 2:31 p.m. assistant director of nursing (ADON) verified R1's cognition is intact, knows how to use her call light, and uses a floor and seat alarm. ADON stated, "I knew she didn't like the alarms." We are in the process of decreasing our alarm use in the facility. "My expectation is residents should be given the opportunity to make their own choices." During interview on 7/19/18, at 2:58 p.m. director of nursing (DON) verified R1's cognition is intact,	F 604	are audible to the resident will be reviewed by the social worker. The medical symptoms justifying the alarming device will be reassessed, assessments/care plans for use of the alarming device will be reviewed for appropriateness, and the resident/family will be interviewed to ensure agreement with use of the alarming device. The facility policy ensures resident/representative agreement with use of alarm alerting devices; the social worker will monitor alarm use implementation for two months to ensure compliance with facility policy. Compliance will be reviewed during the September Quality Assurance and Assessment Committee and ongoing.	

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F 604	Continued From page 5 knows how to use her call light, and uses a floor and seat alarm. DON stated, "My expectation would be for her to be able to make her own choices, if she doesn't want to use the alarms that is her choice." We need to do better training with our staff about residents and their choices. Facility policy, Resident Rights, 11/16, indicated it is the policy of this facility to protect and promote the rights of each resident. In particular, the right to a dignified existence, self-determination, and communication with and access to persons and services staff inside and outside the facility. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care.	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to timely assess, monitor, and treat two non-pressure related skin wounds for 1 of 1 resident (R32) reviewed for non-pressure related skin conditions. Findings include:	F 684	Stewartville Care Center staff believe that quality of care is a fundamental principle that applies to all services provided to the residents. Based on the resident□s comprehensive assessment, the facility ensures that each resident receives treatment and care in accordance with	8/29/18

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F 684	Continued From page 6 R32's Face Sheet, printed 7/19/18, identified diagnoses of left below the knee amputation, diabetes mellitus with diabetic neuropathy, and major depressive disorder. R32's quarterly Minimum Data Set (MDS) an assessment dated 7/12/18, identified R32 to be cognitively intact and to have no skin conditions or pressure ulcers. R32's current care plan revised 7/5/18, identified R31 to have no skin problems at this time, goal to develop no pressure ulcers or skin breakdown, and an approach to monitor skin daily for breakdown or pressure areas. R32's progress note dated 5/15/18, at 4:23 p.m. indicated R32 had an abrasion on middle finger of left hand measured 1 centimeter (cm) long and 0.5 cm wide. Left open to air. R32's Skin and Wound Assessment Record, indicated it was monitored on 5/15/18, 5/23/18, 6/3/18, and 6/11/18 for appearance, size, stage, exudate, odor, and treatment was to keep open to air. On 6/14/18 it read, "Resolved." R32's progress note dated 6/26/18, at 11:20 a.m. Seen by nurse practitioner (NP) today. States the blister on left hand looks irritated, not infected, nursing will monitor for now. R32's Nursing Home Visit note by provider dated 6/26/18, identified R32 is being seen for a sore on the palm of his left hand. He states when he tries to grasp anything and put any weight on it, it is quite painful. It is open. The size of the open area is 0.5 cm - 0.6 cm in diameter. There is	F 684	professional standards of practice. Priority is placed on developing a plan of care for each resident that focuses on person-centered care and reflects individual choices, preferences, goals, as well as the resident□s concerns and needs. The plan describes the services that are to be furnished to attain and maintain the resident□s highest practicable physical, mental and psychosocial well-being. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident□s condition indicates. The resident□s needs including cares and treatments to preserve skin integrity and treat skin problems are identified. A plan of care is then developed, implemented, routinely reevaluated, and revised as necessary based on continuing assessments. The policies and procedures for identifying, reporting, investigating, monitoring and communicating open skin areas and other skin lesions were reviewed and revised. The resident□s skin condition is routinely monitored weekly and more often, if indicated. At the time a non pressure wound is noted, an assessment is completed by a licensed nurse. The medical practitioner is notified, the type of wound is identified (e.g., arterial, venous, stasis, neuropathic), and orders for care/treatment are initiated. The care plan, treatment sheets, and	

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F 684	Continued From page 7 thickened skin surrounding the area almost like a callous. There are no signs or symptoms of infection. Plan is to keep track of it and monitor it and treat as appropriate. R32's progress note dated 7/12/18, at 1:35 p.m. indicated clinic called for right middle finger blister that had been cut away. It shows signs and symptoms of infection and he is diabetic. Wondering if we need antibiotic ointment or an oral antibiotic. Clinic will return my call. R32's, Skin Integrity Event, dated 7/12/18, at 6:32 p.m. identified a laceration on right middle finger, location and size 3 cm x 2 cm with irregular wound edges. Activity during occurrence identified blister cut away. Intervention was a band aide. The doctor was notified and received new orders to apply Mupirocin ointment 2%, apply to right hand middle finger until healed. R32's progress note dated 7/12/18, at 9:31 p.m. indicated a fax was received for new orders, we will try some Bactroban ointment three times a day until healed. R32's Skin and Wound Assessment Record, for right hand middle finger blister, indicated monitoring started 7/7/18 with 100% healthy pink granulation tissue, superficial skin break, no exudate or odor. Skin around wound is healthy and intact. No dressing change. On 7/13/18, with 100% healthy pink granulation tissue. Measured 2 cm x 1.1 cm, superficial skin break with no drainage or odor. Treatment is daily debriding. Does not identify how the skin around the wound looks. During observation and interview on 7/16/18, at	F 684	nursing assistant care guides are updated accordingly. The wound status and characteristics are routinely monitored/documented and the medical practitioner is updated on the (non)healing of the wound. The resident□s legal representative and the dietary staff are notified of open skin lesions. During the mandatory educational meetings August 21, 22 and 23, 2018, the nursing staff will be reinstructed on the facility□s wound policies, procedures and protocols. Instruction will include the need to observe for skin problems and the importance of appropriately identifying, reporting, documenting, monitoring and treating skin lesions. Developing care plans to monitor/treat/prevent pressure related and other types of skin lesions will be addressed. Instruction will be provided to the nursing assistants on the need to be alert to skin injuries/lesions and to immediately report the findings to the licensed nurse. Observing and reporting resident skin concerns will continue to be part of the nursing assistant□s bathing protocol. Resident number 32 had a blister on the right middle finger. The blistered area was monitored weekly by the nurses. The nurse practitioner was notified of the open area and mupirocin ointment was prescribed July 13, 2018. Weekly monitoring records reflected steady improvement in the wound. An August 9, 2018 entry on the Wound Assessment Record indicated that the area was	

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F 684	Continued From page 8 2:15 p.m. R31 was noted to have a scabbed callous looking area on the palm of the left hand under the middle finger. Had a clear piece of tape across it. R31 stated, I need the tape on it to keep the pressure off of it. When queried about the band aide on R31's right middle finger, R31 stated, "Because some dumb nurse hit [cut it off] my blister with a scissors and ever since then it hasn't wanted to heal, they change that everyday too. You know a neat place like this, they hire some shady people, I guess they just hire whoever they can." During observation on 7/17/18, at 3:53 p.m. R31 is lying in bed. Continues to have a piece of tape over the palm of the left hand and a band aid on his right middle finger. During observation and interview on 7/18/18, at 8:15 a.m. R31 is sitting up in his wheelchair watching television. Continues to have a piece of tape over the palm of the left hand and a band aid on his right middle finger. R31 stated that blister on my right middle finger is doing better. "She [reference to a nurse] cut my blister open with a scissors," I don't know why she did that, I think she was trying to be smart, she had a couple other nurses with her. That nurse did this a couple weeks ago. "Pretty much everybody knows you don't cut a blister open, jeez, I don't know where they hire these people!" During interview on 7/18/18, at 1:19 p.m. nursing assistant (NA)-A stated R31 has a callous on his left hand from transfers and he wears a band aide over it to protect it. Two Saturdays ago, I remember giving him a bath, I didn't notice the blister on his right middle finger until later in the day, I reported it immediately to the charge nurse.	F 684	resolved. Resident number 32 also had an open area on the palmer aspect of his left hand under the middle metacarpophalangeal (MCP) joint. A weekly Wound Assessment Record was initiated July 8, 2018 at which time the lesion was described as 0.7 cm by 0.8 cm area of callous like thick skin. The lesion was observed by the nurse practitioner on June 26, 2018 at which time it was described as a possible healing blister from gripping the walker used for ambulation as a result of a below the knee amputation. The recommendation was to wear a padded glove to reduce pressure to the area. The nurses continued to monitor the area which decreased in size and was noted on June 28, 2018 to be a 0.3 cm by 0.4 cm scabbed area. The physician observed the area on July 31 and on August 15, 2018 when the calloused area was noted to be closed. The physician stated there was no concern for cancer. The resident□s care plan was reviewed and updated to reflect healing of the right middle finger blister and continued daily skin monitoring. The medical practitioner will be notified of any signs/symptoms of infection or other skin changes that may require treatment. To monitor compliance with skin assessments, monitoring, and treatment of non-pressure skin lesions, the Director of Nurses/designee will review the Bath Observation sheets and the Skin and Wound Assessment Records weekly for	

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F 684	Continued From page 9 The charge nurse then popped his blister with a scissors. He was not too happy about it. "I was surprised too, because I have a form of diabetes and I know you are not supposed to pop blisters, especially people with diabetes because they have a harder time healing." The other aide I was working with was surprised too. During interview on 7/18/18, at 1:37 p.m. licensed practical nurse (LPN)-A verified they have not been monitoring or documenting the status of the wound on his left palm. "There was no reminder anywhere to do it." During interview on 7/18/18, at 2:43 p.m. registered nurse (RN)-A verified they have not been monitoring the skin area on R31's left palm (the wound was first noted on 6/26/18). RN-A stated, the doctor said if it doesn't heal we might have to do a biopsy. Further stated, "I guess if we are not monitoring it, we would not be able to report it to the doctor to see if it does need to be biopsied." RN-A further verified R31 had an intact blister on his right middle finger that had been cut away with a scissors. RN-A stated, "I would only pop a blister for someone with diabetes under advisement from a medical doctor first." During interview on 7/18/18, at 3:27 p.m. RN-A verified there is no documentation in the medical record regarding doctor/nurse practitioner having been notified of the blister on R31's right middle finger first found on 7/7/18. RN-A stated a medical doctor should have been notified right away and verified a doctor was not notified until 7/12/18. During observation and interview on 7/19/18, at 11:07 a.m. R31 calls the area on his left palm a	F 684	four weeks to ensure appropriate follow up notification and documentation of identified skin wounds/ulcers. If regulatory noncompliance is noted, additional monitoring and staff education will be completed. Compliance will be reviewed at the September quarterly Quality Assurance and Assessment Committee meeting and ongoing.	

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F 684	Continued From page 10	F 684		

sore he has had for the last 6-8 weeks. R31 stated it doesn't bother him unless he is walking and putting pressure on it from using the walker, then it will bleed. The area is below the middle finger on his left palm. Area is circular, has a dark center and callous looking on the outside. R31 stated when he saw the doctor last, she told me it could be cancer.

During interview on 7/19/18, at 11:16 a.m. assistant director of nursing (ADON) verified R31 had a blister on his right middle finger that was popped with a scissor by one of the nurses. ADON stated, it would be a good idea to notify the doctor right away if a diabetic person had a blister that was cut away with a scissors. In regards to the left palm area, ADON verified after R31 was seen by a provider with orders to monitor the left palm, we should have been monitoring it. ADON verified that the 2 skin areas were not care planned and should have been.

During interview on 7/19/18, at 2:49 p.m. director of nursing (DON) stated if the doctor has orders to monitor a skin area it should be monitored. DON stated, I would not have cut open a blister on a diabetic patient, the medical doctor would have to assess and decide what to do. "The best practice would have been to call the medical doctor and have it assessed."

Undated facility policy, Wound and Procedures, indicated the assessment of the condition of the skin provides information on how an individual's overall health. Maintaining skin integral part of providing nursing care; being aware of the resident skin conditions an alterations in the integrity is a critical aspect of providing total resident care. The assessment process would

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F 684	Continued From page 11 identify the potential or actual impairment of the skin integrity.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive pressure ulcer assessment, provide ongoing services and treatments, to promote pressure ulcer healing and prevent infection and other pressure ulcers from developing for 1 of 4 residents (R17) with a current unstageable pressure ulcer located on the left buttock. Findings include: R17's admission Minimum Data Set (MDS) an assessment dated 4/4/18, identified R17 cognition was moderately impaired and had diagnoses which included dementia, presence of other vascular implants and grafts. The MDS	F 686	Based on the resident□s comprehensive assessment, Stewartville Care Center staff provide skin care and treatment consistent with professional standards of practice that reflect resident preferences. The facility has policies and procedures for skin care that are consistent with professional standards of practice and that address the prevention of pressure ulcers/injuries and promote healing of existing pressure wounds. To prevent unavoidable pressure ulcers, the facility□s procedures include 1) identifying whether the resident is at risk for developing a pressure ulcer/injury 2) assessing any pressure ulcers/injuries	8/29/18

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STEWARTVILLE CARE CENTER	120 FOURTH STREET NORTHEAST STEWARTVILLE, MN 55976

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F 686	Continued From page 12 identified R17 required extensive assistance with dressing, personal hygiene, transfers and toileting and bed mobility. The MDS identified R17 was at risk for developing pressure ulcers, had no current pressure ulcers or healed pressure ulcers and had a pressure-reducing mattress. Further the MDS identified R17 had no other skin conditions. In addition, significant change MDS dated 5/10/18 added a dressing application treatment for skin/ulcer. R17's Tissue Tolerance Evaluation form dated 3/28/18, lacked time of entry, identified R17's current skin condition; mepilex on buttocks and a summary read, "The resident is able to reposition himself both in bed and up in chair. He does quite often." R17's Skin Evaluation for Pressure Ulcer Risk form dated 5/8/18, identified R17's Braden score was a 20 (low risk). In summary, "pressure reduction mattress, sore area @ buttocks." R17's care plan revised 5/23/18, revealed R17 has no pressure ulcers. A tissue tolerance eval (evaluation) has been done and indicates that his repositioning is adequate. He has a pressure reduction mattress on bed. R17's goal: will develop no pressure ulcers or skin breakdown with interventions to monitor skin daily for breakdown or pressure areas. R17's Skin and Wound Assessment Record form with an initiated date of 6/9/18, identified a hand written "possibly" pressure ulcer with an open wound inner L (left) buttock, with a check mark on Stage 2 (superficial is crossed off on form-skin break (blister-clear fluid). Measurement on 6/9/18 was 1.0 cm (centimeter) in diameter, a	F 686	which are present upon admission 3) evaluating the resident□s specific risk factors and changes in the resident□s condition that may impact the development and/or healing of a pressure ulcer/injury 4) implementing, monitoring and modifying interventions in an attempt to stabilize, reduce or remove underlying risk factors and 5) providing treatment to heal existing pressure wounds and prevent the development of additional pressure ulcers/injuries. Considering the resident□s choices/preferences, clinical condition, and physician input, a care plan is developed that includes goals and approaches aimed at healing any existing pressure ulcers/injuries, limiting the effects of skin risk factors, and stabilizing/improving related co-morbidities. The policies and procedures for comprehensively assessing the residents□ skin condition and risk factors were reviewed. An evaluation of the resident□s skin condition, skin risk factors, and tissue tolerance will continue to be completed at the time of admission, readmission from the hospital, quarterly, and with significant changes in condition. The physician and dietary manager are notified of open lesions; the plan of care is revised to reflect skin related interventions. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol.	

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F 686	Continued From page 13 scant amount of serosanguineous (bloody) drainage with pain and a mepilex dressing applied. On 6/16/18, the wound is 0.8 cm in diameter, stage 2 checked on form with one spot of blood when dressing removed, no pain, and a mepilex dressing applied. On 6/26/18 wound assessment read, "resolved." R17's Resident Progress Notes for May, June and July 2018, were reviewed and noted the following: May: 5/8/18-has sore are on Left buttocks is hard area, applied calmozinc to area. 5/15/18-CAN (certified nursing assistant) noted a small sore on tailbone region. No other skin issues noted. 5/22/18- no new skin issues noted. 5/29/18- no new skin issues noted. June: 6/9/18- open wound measuring 1.0 cm in diameter on inner L (left) buttock. A scant amount of bleeding noted. Wound was cleansed and a Mepilex was applied. Pink Sheet initiated (wound monitoring form). 6/12/18-open wound on inner L buttock has improved. No drainage noted. Wound was cleaned and a Mepilex applied. Form identified an order dated 6/17/18-6/22/18, to monitor open area on inner L buttocks. Use mepilex dressing and change Q3D (every three days) and PRN (as needed). D/C (discontinue) when resolved. 6/20/18- was seen by provider for recertification (no mention of open wound on buttocks) requirement. 6/22/18-open wound on inner L buttock has	F 686	During the mandatory educational meetings August 21, 22 and 23, 2018, the nursing staff will be reinstructed on the facility□s skin related policies and procedures. Discussion will include the need to 1) notify the physician/nurse practitioner of open skin areas in a timely manner 2) complete an initial assessment at the time a skin lesion is first observed 3) monitor the wound at least weekly and document the characteristics of the wound 4) implement best practice skin-related nursing care and clinician ordered interventions 5) monitor the effectiveness and resident acceptance of the interventions and 6) notify the physician/nurse practitioner of nonhealing/worsening wounds. The skin lesion on the left gluteal fold of resident number 17 was examined by the nurse practitioner July 31, 2018. The subsequent progress note describes the lesion as a very small scabbed area in the left gluteal fold. It measures 0.3 x 0.3 cm. There is no surrounding redness. It is nontender. The nurses continue to monitor and document the wound measurement/appearance weekly; the August 16, 2018 nurse□s note indicates the area has decreased in size to 0.1 cm in diameter with red granulation tissue visible. The care plan has been reviewed; interventions are in place to reduce pressure and promote healing of skin lesions. The medical practitioner will be notified if the wound shows signs of nonhealing or infection.	

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F 686	Continued From page 14 improved. 6/27/18- buttock/coccyx resolved. July: 7/10/18, at midnight, wound on inner L buttock remains open but smaller in size, approximately 0.3 cm in diameter. No drainage noted. Wound was cleaned; barrier cream applied and left OTA (open to air). Monitor daily and apply Mepilex if needed. 7/10/18, at 1:13 p.m. no open areas, no areas of concern. 7/14/18, sore on L buttock is now scabbed over. Barrier cream applied. 7/19/18, at 2:30 a.m. sore on L buttock is scabbed and is without drainage. Barrier cream applied. Observation of R17's left buttock wound on 7/19/18, at 4:30 p.m. with registered nurse (RN)-B. The wound had a thick hard tissue (scab) covering the area and was approximately the size of a thumb nail. At 4:44 p.m. RN-B measured the wound and it measured 1.8 x 1.2 centimeters (cm) and described the wound as a "scab" and said it was a stage 2 pressure ulcer. However, the wound would meet the definition of an unstageable pressure ulcer which is defined as a full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. RN-B said he last seen the wound on Saturday (7/14/18) and felt the wound was getting better. On 7/19/18, at 4:58 p.m. an interview with the Assisted Director of Nursing (ADON) who said she expected staff to follow a wound on our pink sheet (wound monitoring form), the pink sheet is	F 686	To monitor compliance with required assessments and ongoing monitoring/treatment of pressure related skin ulcers, the Director of Nursing/designee will review the Bath Observation sheets and the Skin and Wound Assessment Records weekly for four weeks to ensure appropriate assessments and follow up documentation are completed for the identified skin wounds/ulcers. If regulatory noncompliance is noted, additional monitoring and staff education will be completed. Compliance will be reviewed at the September quarterly Quality Assurance and Assessment (QAA) Committee meeting. Skin issues are reviewed by the QAA Committee on an ongoing basis.	

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F 686	Continued From page 15 a form guide for staff to document the cares for wounds and would also expect the physician to be notified to update them on the wound. On 7/20/18, at 10:26 a.m. call made to nurse practioner (NP)-B, no answer and message left to call back when available. On 7/27/18, at 1:52 p.m. NP-B returned call from 7/20/18 message. NP-B said she was not aware of R17 having a pressure ulcer on the left buttock and would have expected the staff to inform her when it was discovered. On asking for any information regarding the skin assessments, monitoring, interventions, and notification of provider, regarding R17's stage II pressure ulcer (skin broken/open) first discovered on 7/10/18, then found to be an unstageable pressure ulcer on 7/14/18. None was provided by the facility. A facility policy titled, Pressure Sores Monitoring Procedure undated reads; Staff nurse will assess open areas weekly. Staff nurse will document on Skin & Wound Assessment & Record sheet the stage of each area and present treatment.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		8/29/18

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F 690	Continued From page 16 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately assess continence for 1 of 2 residents (R52) reviewed for bowel and bladder. Findings include: R52's diagnosis include pain in the left hip and age related osteoporosis found on the face sheet.	F 690	The goal of Stewartville Care Center staff is that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. Based on the resident□s comprehensive assessment, the facility ensures that a	

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F 690	Continued From page 17 R52's quarterly Minimum Data Set (MDS) an assessment dated 7/3/18, identified R52 able to express ideas and wants as well understood and understands others. Brief interview for mental status (BIMS) indicated cognition was severely impaired. In addition, R52 was totally dependent on staff for transfers and needed extensive assistance with bed mobility and toilet use. R52 was always continent of her bowels. R52's care plan dated 7/17/18, identified, "Pt [patient] is continent of bowel." The NA (nursing assistant) Assignment Sheet received indicated R52 was incontinent of her bowels on: 6/28/18 3 times 6/29/18 1 time and a bed pan offered once 6/30/18 2 times 7/1/18 1 time 7/3 to 7/8/18 No record given for bowels incontinence 7/10/18 1 time 7/11/18 1 time 7/12/18 2 times 7/14/18 No record given for bowel incontinence 7/15/18 1 time 7/16/18 No record given for bowel incontinence 7/17/18 2 times 7/18-7/19/18 No record given for bowel incontinence When interviewed on 7/17/18, at 10:41 a.m. family member (FM)-D Said, "When visiting this morning [R52] was anxious, almost frustrated." FM-D placed call light on but R52 had already gone in her pants. Writer asked if she felt her	F 690	resident who is incontinent of bowel and/or bladder is identified and assessed with the subsequent development of an individualized plan of care that includes interventions to achieve or maintain as much normal bowel and bladder function as possible. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident□s clinical condition demonstrates that catheterization is medically necessary. The policies and procedures for assessing urinary/bowel function and incontinence were reviewed and found appropriate. Bowel and bladder function is considered an important part of the resident□s comprehensive assessment and is recognized as having a significant impact on the residents□ quality of life. During the mandatory educational meetings August 21, 22 and 23, the nursing staff will be instructed on the importance of 1) conducting a comprehensive, accurate assessment of bowel and bladder function 2) ongoing monitoring and tracking of voiding patterns and episodes of incontinence and 3) developing and implementing interventions to promote continence, manage incontinence and prevent infections. The bowel/bladder function of resident number 52 is being reassessed. The resident□s voiding pattern is being monitored for three days after which the data will be analyzed by a registered	

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F 690	Continued From page 18 mother was anxious because she had to go in her pants. FM-D stated, "Yes, probably." FM-D recalled about a month ago her mother said her butt hurt and wonder if it was hurting her because she had to sit in her stool. FM-D said she had not thought about it until now when writer was asking questions. On 7/17/18, at 2:42 p.m. R52 was observed in bed on right side and had a foul odor coming from the room. At 2:45 p.m. writer asked nursing assistant (NA)-E if he could tell writer when R52 was last checked. NA-E referred to a form titled NA Assignment Sheet (used by the nursing assistants for resident information and tracking of cares on a every 2 hour basis) dated 7/17/18, verified R52's last check was noon and not since then. NA-E entered R52's room. NA-E changed R52's incontinent brief requiring her to have her pants changed due to bowel movement that had leaked out of the sides of her disposal brief. NA-E commented R52 must have had a suppository because of the amount of stool to be cleaned up. Following the incontinence cares for R52 the medication administration record was reviewed and did not indicate a suppository was given this day. On 7/18/18, at 8:19 a.m. R52's had been observed in bed, NA-F was in room at this time and said R52 had a bowel movement and was getting her back in her chair. When interviewed on 7/19/18, at 11:19 a.m. NA-C, said R52 is hardly ever incontinent, sometimes she is then they will change her.	F 690	nurse. The care plan will then be reviewed by the nurse and staff interventions will be revised as necessary to promote continence and manage incontinence. The current care plan has been updated to reflect the resident□s bowel incontinence. To monitor compliance, the MDS (minimum data set) Coordinator will conduct a three-month audit of MDS Section H 0300 and 0400. Residents who are coded as always continent will be reviewed by the Assistant Director of Nursing/designee to ensure accuracy of the assessment data. Residents showing a decline in urinary and/or bowel continence will be reviewed to determine whether their toileting plan was appropriately reevaluated. If noncompliance with reassessments of bowel/bladder function and care planning is identified, additional auditing and staff training will be done. The residents□ bowel/bladder function and toileting needs will continue to be reviewed during the quarterly interdisciplinary care conferences; modifications will be made to the care plan as necessary. Compliance will be reviewed during the September 2018 quarterly Quality Assurance and Assessment Committee meeting.	

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F 690	Continued From page 19 When interviewed on 7/19/18, at 11:36 a.m. licensed practical nurse (LPN)-B said R52 is incontinent of stool and she will try to get her to the toilet or commode. When interviewed on 7/19/18, at 3:04 p.m. assisted director of nursing (ADON) said to determine residents incontinence/continence assessments are completed for MDS, a 3 day bowel and bladder and TENA (company who sell incontinent products) assessment. The assessments include a look at the residents, although ADON said R52 is usually continent of stool. Follow up interview on 7/19/18, at 3:50 p.m. ADON expectation would be to check on R52 every 2 to 3 hours due to cognition. ADON verified there is no bowel incontinence interventions in place because they had an inaccurate bowel assessment.	F 690		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, to provide pain management including a comprehensive reassessment and ongoing monitoring for uncontrolled pain and timely interventions to relieve severe pain for 1 of 1 resident (R36) reviewed for pain. Although the	F 697	Past noncompliance-no plan of correction required	8/31/18

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F 697	Continued From page 20	F 697		

facility has since implemented corrective action, R36 experienced actual harm when staff failed to collaborate with other health professionals and address ongoing severe pain for several days. Therefore this is being cited as past noncompliance.

Findings include:

R36's face sheet indicated R36 had been admitted to facility on 3/19/18, with primary diagnosis including: healing T11 (Thoracic part of spine) compression fracture, history of falls, low back pain, unspecified site-osteopenia, unspecified dementia without behavioral disturbance.

R36's significant change Minimum Data Set (MDS) assessment dated 4/24/18, indicated R36 had moderate cognitive impairment, required one staff assist for bed mobility, transfers, dressing, toileting, and personal hygiene needs, and had pain described as frequent which was present during the time of the assessment. The MDS further indicated R36 required as needed (PRN) medications in addition to scheduled pain medications.

R36's care plan dated 5/8/18, indicated R36 had moderately impaired decision-making and required assistance of one staff for activities of daily living (ADL)s, and transfers. The care plan included a problem area initiated 6/6/18 regarding pain due to acute onset of back pain compression fractures. Interventions included: "staff to administrator pain medication as ordered, monitor effectiveness and report to medical doctor (MD)/nurse practitioner (NP)." The care plan goal included: R36 "will have no increased complaints

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of pain and will have relief after receiving pain medications."

Physician's order sheet dated 5/8/18, included:
1) Decrease oxycodone to 2.5 mg (milligrams) four times daily and 2.5 mg PRN every four hours.
2) Inform NP if R36 has increased verbal report or nonverbal display of pain with dose reduction.

A physician's progress note date 5/14/18, assessment plan show diagnosis of pain low back, fracture T11-12 wedge compression, osteoporosis spine with pathological fracture subsequent, osteoarthritis. In addition, indicated that pain and depression concerns were reviewed with staff and all agree no changes to current mediations.

NP-A's progress note date 5/18/18 (Friday), indicated she had been called by facility staff regarding R36 having increased severity of pain located in low thoracic spine since the previous day. The note indicated the resident had increased yelling out behaviors that had started the prior evening and "continued today". The NP indicated R36 was quite uncomfortable and the current pain management regimen was not effective. "New orders for increased pain medications given. To re-evaluate [R36's] back pain on 5/22/18, when back in facility."

Nursing progress notes dated 5/19/18 (Saturday) at 5:05 a.m. included: "Resident called out loudly most of night. Administered PRN Oxycodone 5 mg with no or little relief in an hour. Difficult to administer medications due to non-compliance, didn't understand what was going on, biting medicine cup and moving it so that pills fell out

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F 697	Continued From page 22	F 697		

and had to search through bedding until found. After administration, resident continued to scream various things repeatedly such as "Water!" (When she was offered she wouldn't drink but continued to scream out "water!") Also screaming for "help" even though she is in no acute distress. She was unable to verbalize anything that made sense except random words she was hollering out. Behaviors present even after 3 staff tried to calm resident. Attempted massage, 1:1 time, turning, repositioning (in which she screamed the entire time she was being moved), toileted 3 times, transferred out of bed to chair, food and drink offered etc. Resident is currently still crying out but she did voice to staff she didn't know she was calling out."

Nursing progress notes dated 5/20/18 (Sunday) at 12:00 a.m. included: "Resident slept for a short time this evening, then woke around 2300 (11:00 p.m.), yelling for help. UA (unable) to verbalize her needs. When asked about her level of pain, she said "Yes." Oxycodone 2.5 mg given along with ice pack. At 2:00 a.m. Resident sleeping off and on, and is now in her recliner yelling for help. She states that the pain in her back is worse. Another 2.5 mg Oxy (oxycodone) was given. At 4:30 a.m. Resident moved to bed and has been yelling for help since that time. Redirection, repositioning, reassurance seem to have no effect. When she does get words out, she reports terrible pain in her back and reaches for her mid to lower back. Voltaren (topical analgesic) was used earlier and ice pack was just placed. Oxy 5 mg given. "

Nursing progress notes dated 5/21/18 (Monday) at 1:30 a.m. included: "Resident has been yelling for help since she went to bed at 2100 (9:00

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p.m.). She is unable to say what she needs or what is wrong. Both arms are behind her back. Redirection, repositioning, reassurance, toileting have had no effect. Voltaren applied and ice pack was placed. Oxy 5 mg given at 2100 and 0130 (1:30 a.m.). She falls asleep easily but awakens and yells "help" very loudly."

Nursing progress notes dated 5/22/18 (Tuesday) included: "[R36] was seen at the facility by NP-A." NP-A's progress note dated 5/22/18 included, "over the past several days had significant exacerbation of thoracic back pain and is very uncomfortable. Nursing staff reports that [R36] has been sleeping very poorly at night and is frequently yelling out "Help me! Help me!" At this point, she has had very little sleep over the past two days. [R36] appears very anxious and restless with facial grimacing and pain behaviors that are evident. [R36] having significant pain with any movement, current pain management is not effective. Recommendation to send [R36] to Emergency Department (ED) for further evaluation."

On 5/22/18 at 8:39 p. m., the facility received a call from St. Mary's ED (emergency department) that R36 was being admitted to the hospital for control of back pain, and reported R36 had been identified as having new compression fractures.

The hospital Discharge Summary dated 6/5/18, included on page 3, indicated: computed tomography (CT) scan of the thoracolumbar spine displayed a new compression fracture to L1 with mild posterior retropulsion, (vertebral fracture fragment that is displaced into the spinal canal, thereby potentially causing spinal cord injury) along with the T11, T12 fractures noted prior.

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Spine surgery was consulted and recommended vertebroplasty (procedure for stabilizing compression fractures in the spine) which was completed successfully on 5/31/18, with much improved back pain.

A pain interview for the MDS 3.0 section J, Health Conditions, with an assessment reference date of 4/24/18, indicated: pain present- "Yes" with a hand written note, "Better today!" The resident's pain frequency was identified as a frequent with a hand written note, "New medications helping, Ice helps." The resident's pain intensity was identified as a 10 (scale of 0=no pain, to 10=worst pain you can imagine).

A subsequent pain interview for the MDS 3.0 assessment reference date of 6/11/18, indicated pain was present, and the frequency was documented as "occasionally" and the pain intensity was identified as a 7.

Although the provider was asked about a reassessment of R36's pain management, for the dates of 5/18 through 5/22/18, none was provided.

On 7/18/18 at 12:30 p.m., trained medication aide (TMA)-B stated "[R36's] pain seemed to be increasing about a week or two week after her last fall (fall on 5/5/18). At that time they called the doctor to get an increase in pain medication. When she was not able to get any relief from the pain, it seemed the scheduled dose would not hold her for very long and the PRN medications were not helping either. The NP saw her on 5/22/18 and sent her to the hospital for pain control.

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On 7/18/18, at 1:24 p.m., during interview with licensed practical nurse (LPN)-B regarding pain management for R36 LPN-B stated, "I would do an assessment and find out where they are having pain and the severity of the pain. Depending on the location and severity, I would reposition, try ice, etc. If that did not work, I would see if PRN medications could be given, and would verify when the scheduled pain medications had last been given. If there was no improvement in pain control then I would take their vitals and update the doctor or nurse practioner (NP) regarding pain symptoms, background, assessments done, and recommendations, by communicate note or calling them.

On 7/18/18 at 01:34 p.m., registered nurse (RN)-A stated review of progress notes included notification of the NP regarding R36's increased pain on 5/18/18. On 5/18/18, the NP ordered an increase in narcotics. When questioned about whether the NP had been notified of the resident's uncontrolled pain even with the increase of narcotics, RN-A verified the NP was notified about the resident's continued pain until she visited the patient again on 5/22/18.

On 7/19/18 at 9:14 a.m., the assistant director of nursing (ADON) stated during interview, she had reviewed nursing notes. The ADON verified neither the NP or medical doctor (MD) had been notified of R36's uncontrolled pain which developed following the NPs assessment 5/18/18, to 5/22/18 when the NP was back at the facility to assess the resident. When questioned about when staff were expected to call the NP/MD, the ADON stated, "I would expect staff to call the NP/MD or on-call provider to update them

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F 697	Continued From page 26 on increase pain, in order to get further recommendations." During observations on 7/16/18 at 3:30 p.m., staff were observed to remind the resident to wait for help to transfer into recliner chair, the resident had no signs of discomfort. On 7/17/18 at 2:00 p.m., R36 was observed to be sitting in a recliner chair in the lobby watching TV. The resident exhibited no signs of pain or discomfort at that time. On 7/18/18 at 7:19 a.m., R36 was observed in the dining room sitting eating breakfast. The resident exhibited no signs of pain or discomfort. On 7/18/18 at 10:23 a.m., R36 was observed sitting in a recliner in her room. The resident's eyes were closed and she had no signs of pain or discomfort. Breathing is regular and relaxed. The facility's undated policy, Resident Pain Evaluation Protocol, indicated staff were to plan interventions conferring with the resident's medical provider as necessary.	F 697		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		8/29/18

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F 880	Continued From page 27 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 28 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an on-going infection control program, which included analysis of infections and failed to report an outbreak of influenza A for 2 of 2 residents (R205 and R15), who had been diagnosed with influenza A. This had the potential to affect all residents in the facility. Findings include: Review of the facility Infection Control Logs/Resident Lists/Resident Information/Classification/History/Diagnostic/Anti microbial Starts/Other Information sheets dated 12/29/17 through 7/16/18, revealed the following information: 12/29/17 - 1 pneumonia 1/2018 - 1 left finger infection, 2 cellulitis, 1 skin infection right abdomen 2/2018 - 2 Influenza A, 3 urinary tract infections (UTI), 2 cellulitis 3/2018 - 3 UTI, 1 respiratory, 1 tooth infection, 1 left eye infection, 2 respiratory	F 880	Stewartville Care Center has established and maintains an infection prevention and control program (IPCP) designed to provide a safe and sanitary environment for the residents and reduce the risk of the development and transmission of communicable diseases and infections. The infection control program includes a system for 1) identifying, reporting, investigating, controlling, and preventing infections in the facility 2) determining the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintaining a record of incidences of infections and tracking any corrective actions taken. There is an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility and procedures for required reporting of communicable disease or	

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F 880	Continued From page 29 4/2018 - 1 upper respiratory infection, 1 Influenza B (new admit), 1 UTI 5/2018 - 1 pneumonia, 2 cellulitis, 1 left jaw infection, 3 UTI, 1 blood infection 6/2018 - 2 UTI, 1 respiratory 7/2018 - 4 UTI No information was provided regarding analysis of infections since 12/2017. In addition, the facility lacked to report an outbreak of influenza for the following: R205's lab results dated 2/7/18, identified influenza A as positive. R15's lab results dated 2/11/18, identified influenza A as positive. During interview on 7/17/18, at 10:42 a.m., the assistant director of nursing (ADON) stated she was responsible for infection control information. ADON stated I have tracking information for infections only, I do not write up anything formally for analysis of infections. We talk about infections at our infection control meetings monthly and at quality assessment performance improvement (QAPI) every 3 months. If we notice a pattern with infections or something is going on, we have all the staff review handwashing policy and procedures. ADON stated for repeat of UTIs monthly she had personally talked to the nursing assistants about handwashing, but did not do any formal in-service for education with staff for UTI's. ADON stated I do not document when staff are educated regarding infection procedures reviewed for concerns identified. ADON stated I did not report the two cases of Influenza A to the Minnesota Department of Health agency and stated she would be the person responsible for	F 880	infections. Procedures also address standard and transmission-based precautions to prevent spread of infections, when and how isolation should be used for a resident, the circumstances under which the facility prohibits employees with a communicable disease or infected skin lesions from direct resident contact, and staff hand hygiene procedures. The facility□s infections control policies and procedures were reviewed and revised to clarify the need to analyze infection-related data and report outbreaks of influenza. The IPCP will be reviewed annually and updated as necessary. Antibiotic stewardship and the infection control policy changes will be reviewed with the Medical Director. The facility□s monthly infection control log tracks the resident name, admission date, site of infection, infection related symptoms, whether a culture/x-ray was done and the date, causative organism (if cultured), antibiotic (if prescribed), whether the infection was isolated or nosocomial, whether a reculture was done, and the date the infection resolved. Collected data will be analyzed including identifying infection trends and clustering; comparisons will be made between the number/type of infections for the current quarter with the previous quarter and the previous year. The results of the monthly analysis will be reported at the monthly infection control committee meeting.	

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F 880	Continued From page 30 reporting to the state agency. ADON confirmed R205 and R15 had developed symptoms of influenza in the facility. ADON stated R15 was sent to the hospital and admitted due to symptoms and was diagnosed with Influenza A and R205 was swabbed and had positive results for Influenza A. The facility policy Management of Outbreak of Communicable Diseases, undated indicated Purpose: Outbreaks of communicable diseases within the facility will be promptly identified and appropriately handled. Procedure: 6. Administration will be responsible for: g. Forwarding Communicable Disease Reports to the health department. The facility policy Facility Infection Control, undated, indicated Purpose: The primary purposes of this facility's infection control policies and procedures are to establish guidelines to follow to provide a safe and sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Procedure: 2. The objectives of our infection control policies and procedures are to: 2. d. Maintain records of incidents and corrective actions related to infections.	F 880	The infection control nurse has reviewed the infection control regulations with a focus on the requirements for infection surveillance, data analysis, and reporting requirements. A comprehensive infection control resource manual is available for reference. During the mandatory staff meetings August 21, 22 and 23, 2018, licensed nurses will be instructed on the importance of reporting symptoms of infection and the criteria to consider when notifying the clinician of symptoms which may be indicative of an infection. The Director of Nurses/designee will monitor compliance with regulatory requirements and facility policies for infection control analysis/surveillance for the next three months through a review of the infection control logs and summary findings. If noncompliance is noted, additional training and auditing will be done. Compliance will be reviewed during the September 2018 Quality Assurance and Assessment Committee meeting and ongoing.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 881		8/29/18

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F 881	Continued From page 31 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an antibiotic stewardship program, which included the development of protocols and a system to monitor antibiotic use, to include how the program will be implemented and antibiotic use will be monitored. This deficient practice had the potential to affect all 53 residents who resided in the facility. Findings include: A review of the facility's infection control surveillance program was conducted on 7/17/18, at 10:42 a.m., with the assistant director of nursing (ADON). The facility lacked development of protocols for a facility-wide system to monitor the use of antibiotics which includes (but not limited to) appropriate prescribing of antibiotics, criteria before antibiotic use and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. During interview on 7/17/18, at 10:42 a.m., the ADON stated she was responsible for infection control information. ADON stated she had not developed a formal policy and procedure for antibiotic stewardship program.	F 881	Stewartville Care Center has established and maintains an infection prevention and control program (IPCP) that prevents the development and transmission of communicable diseases and infections. The program is designed to promote the appropriate use of antibiotics and includes a system for monitoring antibiotic use with the goal to improve resident outcomes and reduce antibiotic resistance. The antibiotic stewardship program includes antibiotic use protocols to 1) develop, promote, and implement a facility-wide system to monitor the use of antibiotics 2) optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic and 3) reduce the risk of adverse events from unnecessary or inappropriate antibiotic use. The protocols address antibiotic prescribing practices such as documentation of the indication, dose, and duration of the antibiotic. Laboratory reports will be reviewed to determine if the antibiotic is indicated or needs to be adjusted. The facility□s monthly infection control log tracks the resident name, admission date, site of infection, infection related symptoms, whether a culture/x-ray was done and the date, causative organism (if cultured), antibiotic (if prescribed),	

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F 881	Continued From page 32	F 881	whether the infection was isolated or nosocomial, whether a reculture was done, and the date the infection resolved. The infection control nurse will analyze the collected data to determine if antibiotic use is in compliance with the facility□s stewardship program and accepted practice standards. Antibiotic use outside of the facility protocols will be reviewed with the prescribing clinician and/or the medical director. The infection control nurse has reviewed the antibiotic stewardship regulations and a comprehensive infection control resource manual is available for reference. The infection control nurse plans to attend an August 22, 2018 seminar on antibiotic stewardship presented by HealthCare Academy. During the mandatory staff meetings August 21, 22 and 23, 2018, the nurses will be instructed to notify the infection control nurse when a resident is prescribed an antibiotic or returns from the hospital with an order for an antibiotic. The criteria and practice standards for antibiotic use and the data needed to effectively track antibiotic prescribing practices and promote effective antibiotic stewardship will be addressed. Compliance with regulatory requirements and facility policies for antibiotic stewardship will be monitored by the Director of Nursing/designee for the next three months through a review of the infection control tracking data and	

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F 881	Continued From page 33	F 881	subsequent data analysis. If noncompliance is noted, additional training and auditing will be done. Compliance will be reviewed during the quarterly September 2018 Quality Assurance and Assessment Committee meeting and ongoing.	

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Stewartville Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245349	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWARTVILLE CARE CENTER	**120 FOURTH STREET NORTHEAST** **STEWARTVILLE, MN 55976**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Stewartville Care Center is a 2-story building. The building was constructed at 2 different times. The original building was constructed in 1970 and was determined to be of Type II(111) construction. In 1974, addition was constructed and was determined to be of Type II(111) construction. The building is protected by a full fire sprinkler system. 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 57 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101	K 291		8/8/18

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K 291	Continued From page 2 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.2.9.1, 19.2.9.1) This deficient practice could affect the safety of all (10) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/18/2018, observation and documentation reviewed revealed the following: During documentation review no information was provided to confirm annual 90 minute testing of emergency light units This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	The Testing of Battery Backup Lighting Checklist which confirms the required annual 90 minute testing of the emergency light units was updated to include the month the maintenance staff conducted the testing. The Environmental Services Director will monitor compliance with documentation requirements.	
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed	K 341		7/19/18

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K 341	Continued From page 3 at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8) This deficient practice could affect the safety of all (54) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/18/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility: Main Floor (100 Wing at East Fire Door separation) - Fire Alarm System wiring above ceiling tile unprotected - wire-nutted together, but not contained in a junction box This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 341	The system contractor, Tech One, installed a J Box to contain the unprotected fire alarm system wire nuts located in the ceiling area above the 100 Wing at the east fire door separation. The Environmental Services Director will monitor compliance with the protection of fire alarm system electrical wires	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		8/23/18

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K 353	Continued From page 4 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (9.7.5, 9.7.7, 9.7.8, and NFPA 25) This deficient practice could affect the safety of all (10) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/18/2018, observations and staff interview revealed the following: Observation during the walk-through of the facility: Garden Floor / Med Room - found high vertical storage on shelving This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	Date the sprinkler system was checked: May 31, 2018 System test provided by: Olympic Fire Protection Company Water system supply source: City of Stewartville The items on the shelving that exceeded the height restrictions were removed. A red line was painted on the wall 18 inches below the sprinkler to define the maximum height of storage on the medication room shelving. Signs were placed instructing staff not to store items extending above the red line. Shelf storage height restrictions will be addressed during the August 21, 22, and 23, 2018 mandatory educational meetings. The Environmental Services Director will	

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K 353	Continued From page 5	K 353	monitor compliance with storage height restrictions and clearance in the vicinity of sprinkler heads.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2) This deficient practice could affect the safety of all (20) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/18/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility: (1) Garden Floor / Laundry Room - obstructed access to electrical shut off panel; (2) Garden Floor / North Wing - unsecured electrical panel in resident hallway; (3) Garden Floor / LB2 - unsecured electrical panel in resident hallway	K 511	All items obstructing access to the electrical shut off panel in the Garden Floor laundry room were removed. The laundry staff was instructed not to place items in front of the panel and that the panel is to remain unobstructed and accessible at all times. During the mandatory educational meetings on August 21, 22, and 23, the staff will be instructed not to block access to electrical panels. New locks were purchased and installed August 2, 2018 on the two previously unsecured electrical panels in the Garden Floor resident hallways. The panel will be locked at all times; keys were provided to the maintenance and administrative staff	8/23/18

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K 511	Continued From page 6 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 511	for emergency access. The Environmental Services Director will monitor compliance with electrical panel access and security.	
K 900 SS=E	Health Care Facilities Code - Other CFR(s): NFPA 101 Health Care Facilities Code - Other List in the REMARKS section any NFPA 99 requirements (excluding Chapter 7, 8, 12, and 13) that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Health Care Facilities Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (NFPA 99 - 11.5.2.1) This deficient practice could affect the safety of all (54) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/18/2018, observation and documentation reviewed revealed the following: During documentation review no information was provided regarding Med Gas training of staff This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 900	Staff will be trained on the storage and handling precautions for medical gases during the mandatory educational meetings scheduled for August 21, 22, and 23, 2018. The National Fire Protection Association January 2018 publication Medical Gas Cylinder Storage will be used as one of the educational resources. Use and handling of medical gases is included in the orientation of new staff and annual staff training. The Assistant Director of Nursing will monitor compliance with required staff training on medical gas storage and handling.	8/23/18
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		7/30/18

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K 914	Continued From page 7 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (6.3.4 (NFPA 99)) This deficient practice could affect the safety of all (54) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/18/2018, observation and documentation reviewed revealed the following: During documentation review no information was provided regarding electrical outlet pull-force	K 914	The environmental policies and procedures have been updated to include annual outlet pull-force testing. All electrical receptacles have been pull-force tested. The date and results of the testing are recorded in the designated log book. The Environmental Services Director will monitor compliance with the annual pull-force testing requirements through review of the pull-test verification log book.	

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K 914	Continued From page 8 testing. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 914		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5)	K 920	All power strips that do not meet NFPA 101 standards have been removed from service. During the mandatory educational meeting August 21, 22, and 23, 2018,	8/23/18

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K 920	Continued From page 9 This deficient practice could affect the safety of all (54) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/18/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility: (1) Garden Floor / Therapy Rm - refrigerator connected to power strip; (2) Main Floor / Rm 108 - refrigerator connected to power strip; (3) Main Floor / Rm 106 - power strip connected to another power strip This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 920	staff will be educated on the safe and acceptable use of power strips/extension cords and reminded to be alert for noncompliant use in the resident care areas. Families/legal representatives are informed of the restrictions on power strip/extension cord use at the time of admission. Safe and acceptable use of UL power strips/extension cords will be addressed in the facility newsletter. The Environmental Services Director will monitor compliance with acceptable use of power strips and extension cords.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K 923		8/23/18

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K 923	Continued From page 10 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (11.6.2.) This deficient practice could affect the safety of all (54) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 10:00 AM and 02:30 PM on 07/19/2018, observations and staff interview revealed the following: Observed during the walk-through of the facility: (1) Main Floor / Rm 111 - 2 oxygen cylinders were free-standing and unsecured; (2) Main Floor / Med Rm at the Nurses Station had full and empty	K 923	Empty oxygen cylinders were removed from resident room 111 and the first floor medications room. The staff have been informed that 1) empty oxygen tanks are to be taken immediately to the oxygen storage room and placed in the racks in the designated area and 2) only one full oxygen tank secured to a cart is to be stored in the first floor medication room. The policies and procedures for handling and storage of oxygen tanks will be reviewed at the mandatory staff education meetings August 21, 22, and 23, 2018. The Director of Nursing/Designee will be responsible for monitoring the safe	

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K 923	Continued From page 11 oxygen cylinders stored in same rack with no separation, and no in-room signage This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 923	storage of oxygen cylinders. Storage of empty and full oxygen cylinders storage must be segregated. There are labeled areas for placement of empty and full tanks in the lower level oxygen storage room. Empty oxygen tanks are to be taken immediately to the lower level storage room. Empty tanks are not to be stored/placed in the upper level medication room. One full oxygen tank secured in a cart is permissible in the medication room. NOTE IN STAFF PAYCHECKS	