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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: DS2N

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245328**

2.STATE VENDOR OR MEDICAID NO.
(L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLY RESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

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 **09/05/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **101** (L18)

13.Total Certified Beds **101** (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
	101			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Patricia Halverson, Unit Supervisor — 09/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Heath
Enforcement Specialist — 10/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 10/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/15/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245328

September 14, 2014

Mr. Frank Robinson, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, Minnesota 55013

Dear Mr. Robinson:

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 September 2, 2014 the above facility is certified for:

101 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 101 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.

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

Sincerely,

Mark Meath

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 15, 2014

Mr. Frank Robinson, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, Minnesota 55013

RE: Project Number S5328022

Dear Mr. Robinson:

On August 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 25, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 2, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 25, 2014, effective September 2, 2014 and therefore remedies outlined in our letter to you dated August 6, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

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

Telephone: (651) 201-4118 Fax: (651) 215-9697 5328r14

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245328	A. Building B. Wing	9/5/2014

Name of Facility	Street Address, City, State, Zip Code
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **09/02/2014**
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/02/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/02/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/02/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **09/02/2014**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/02/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/02/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PLH/mm	09/15/2014	12835	09/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/25/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: DS2N

Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245328**

2.STATE VENDOR OR MEDICAID NO.
(L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLY RESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

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 **07/25/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **101** (L18)

13.Total Certified Beds **101** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 08/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/11/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/15/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 245328

On July 25, 2014, a standard survey was completed at this facility. Deficiencies were cited, whereby correction is required. The facility has been given an opportunity to correct before remedies would be imposed. In addition, at the time of the survey an investigation of complaint number H5328017 was conducted and found to be unsubstantiated. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 6, 2014

Mr. Frank Robinson, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, Minnesota 55013

RE: Project Number S5328022, H5328017

Dear Mr. Robinson:

On July 25, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 25, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5328017.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 25, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5328017 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Patricia Halverson, Supervisor
Duluth Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 340-6623

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 3, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 3, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 25, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 25, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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

5328s14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Census: 92 An investigation of complaint H5328017 was investigated and not substantiated with no deficiencies issued.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any	F 164		9/2/14

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

Electronically Signed | 08/18/2014

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
	245328	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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 164	Continued From page 1 individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide privacy for 2 of 4 residents (R55, R166) observed during personal cares. Findings include: On 7/24/14, at 1:20 p.m. and on 7/25/14, at 8:20 a.m. R55 received eye drops in the dining room. On 7/24/14, at 9:53 a.m. R166's urinary leg bag was emptied in a public area. R55 was in the dining area of the Martha's House unit on 7/24/14, at 9:42 a.m. when Trained medication aid (TMA)-A administered eye drops in both eyes. Another resident was seated at the table with R55 and another 10 residents were present in the dining room at the time. On 7/24/14, at 1:20 p.m. TMA-A was interviewed and stated she always administered eye drops in	F 164	F 164 In relation to Personal Privacy/Confidentiality of Records, it is the policy of the facility to provide personal privacy for medical treatment, written and telephone communications, personal care, visits and meetings of family and resident groups.Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. In relation to R55, the TMA was re-educated to ensure a private area is provided when administering eye drops. In relation to R166, the NAR was re-educated on the resident'□s right to privacy and emptying of a urinary leg bag. To ensure other residents are not affected by this deficient practice,observational audits will be conducted by nursing daily over the next two weeks, then weekly for	

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F 164	Continued From page 2 the dining room. "If you ask the resident and it's ok with them then you can give eye drops in public areas. I never thought about asking the other residents in the area if it bothered them." On 7/25/14, at 8:20 a.m. TMA-B administered eye drops to R55 in the dining room in the Martha's House unit. Another resident was seated at the table at the time. After administering the eye drops TMA-B stated she should have moved R55 to a more private place to administer the eye drops. R55's Order Summary Report signed by the physician on 6/20/14, directed staff to administer Natural Balance Tears solution 4% to both eyes three times a day for tear film insufficiency. R166 was sleeping in a recliner in the day room area in the Martha's House unit on 7/24/14, at 9:53 a.m. Nursing assistant (NA)-A applied lotion, stockinettes and blue braces to both of R166's lower legs. NA-A loosened R166's urinary drainage leg bag from the left leg, donned gloves, cleaned the drain port with alcohol and drained the urine into a graduate. NA-A removed the gloves, adjusted R166's pant leg and took the graduate to the soiled utility room to empty. There were 12 other residents in the area along with three visitors. NA-A stated he/she knew they were not suppose to do it there but it needed to be done. R166's care plan revised on 3/26/14, indicated R166 had an indwelling catheter due to urinary retention and obstruction. On 7/25/14, at 8:00 a.m. the director of nursing (DON) stated eye drops should be given in a	F 164	one month and monthly thereafter. To ensure this deficient practice does not reoccur, re-education on the policy for Quality of Life - Dignity, will be reinforced to all staff members. To ensure compliance with this policy, The Quality Assurance Performance Improvement(QAPI) team will determine if discontinuation of audits is warranted. Responsible Person: Director of Nursing or Designee	

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F 164	Continued From page 3 private area if the resident was willing to go and the urinary drainage bag should not have been emptied in a public area. The facility's Dignity policy revised 10/09, indicated staff would promote, maintain and protect the resident's privacy. This included bodily privacy during assistance with personal cares and during treatment procedures. The facility's Instillation of Eye Drops policy revised 2/14 directed staff to allow the resident as much privacy as possible.	F 164		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor resident choice regarding when to get up in the morning, when to go to bed at night, bathing frequency and type of bathing for 4 of 4 residents (R45, R87, R230, R43) reviewed for choices. Findings include: R45's Admission Record dated 5/27/14, identified diagnoses that included multiple sclerosis. The admission Minimum Data Set (MDS) dated	F 242	F 242 In relation to Self-Determination □ Right to Make Choices, it is the policy of the facility that residents have the right to choose activities, schedules and health care consistent with his/her interests&and make choices about aspects of his or her life that are significant to the resident. The facility has, and will continue to honor resident choices and requests. As it relates to R45, the resident□s care plan and NAR care sheets have been	9/2/14

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F 242	Continued From page 4 6/13/14, indicated R45 had moderate cognitive impairment and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, personal hygiene and bathing. The MDS further identified R45 did not ambulate, required minimal assistance of one staff with eating, and was frequently incontinent of bowel and bladder. On 7/23/14, at 12:48 p.m. R45 was interviewed and stated she was unable to choose what time she got up in the morning, choose what time she went to bed at night, the frequency of bathing or if she would like a tub bath or a shower. R45 stated she would like to get up before 8:00 a.m., and go to bed around 7:00 p.m. but it doesn't always happen. R45 stated she requires assistance of a mechanical lift, and staff gets her up and puts her to bed when they are available. R45 further stated she was unable to choose how many times a week she took a bath, and was unable to have her preference of a shower. The Activity Interview for Daily and Activity Preferences dated 6/3/14, identified it was very important for R45 to choose between a tub bath, shower, bed bath or sponge bath, and very important to choose her own bedtime. The activity interview did not address the importance of when to get up in the morning, or frequency of bathing. R87's Record of Admission updated 2/7/13, identified diagnoses that included dysphagia (difficulty swallowing), disorder of the esophagus, congestive heart failure, and atrial fibrillation. R87's quarterly MDS dated 4/30/14, indicated R87 was cognitively intact. The MDS further indicated R87 required extensive assistance of one staff for bathing, set up assistance of one	F 242	updated to reflect the resident□s preferences to get up prior to 8:00a.m.and go to bed around 7:00p.m. As it relates to R43, the resident□'s care plan and NAR care sheets have been updated to reflect the resident'□s preference to have two baths per week. The resident has been scheduled to have a bath every Monday and Thursday to honor resident'□s choice. As it relates to R87, the resident's care plan and NAR sheets have been updated to reflect the resident's preference to get up at 9:00a.m. Furthermore, the resident's preferences related to bathing and bedtime have been updated. As it relates to R230, the patient discharged from facility. All facility residents will specifically be asked about preferences related to aforementioned to ensure choices are being honored. To address the deficient practices related to honoring resident choices for getting up in the morning, going to bed at night, bathing frequency and type of bath, activities and nursing will ensure resident choices are addressed and care planned at the time of admit. Such preferences will be added on the care plan and available to the NARs. To ensure other residents are not affected by this deficient practice, all residents will	

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F 242	Continued From page 5 staff for personal hygiene, and set up assistance for bed mobility, transfers, ambulation, dressing and eating. On 7/23/14, at 1:37 p.m. R87 was interviewed and stated she was not able to choose what time she got up in the morning. R87 stated staff assisted her with getting up at about 7:00 a.m., but she would rather sleep until 9:00 a.m. R87 stated she has told staff, but they still got her up at 7:00 a.m.. The Preferences for Customary Routine and Activities/Activity Assessment dated 11/1/13, identified it was very important for R87 to choose between a tub bath, shower, bed bath or sponge bath, and very important to choose her bedtime. The activity assessment did not address the importance of choosing when to get up in the morning. R230's Admission Record dated 7/15/14, identified diagnoses that included hip joint replacement, moderate chronic kidney disease and hypertension. The physician's progress note dated 7/24/14, identified R230 as alert and oriented. The care plan dated 7/15/14, indicated R230 required assistance of one staff for bed mobility, transfers, ambulation, dressing, grooming and bathing. The care plan further identified R230 as having minimal bladder incontinence. On 7/23/14, at 2:06 p.m. R230 was interviewed and stated she was not able to choose when to get up in the morning. R230 stated she gets up early, and would rather sleep until she is ready to get up. R230 also stated she gets a shower once a week, but would prefer more. A copy of the	F 242	be interviewed, as applicable, to ensure preferences are being honored. Updates to care plans and care sheets will be made accordingly by nursing staff. To ensure deficient practices do not re-occur and compliance is sustained, the activity department will follow-up 5-7 days after admit, during a significant change or annual assessment to ensure resident□s preferences are being honored. The facility will continue to ensure resident choices and preferences are honored by reviewing the care plan on a quarterly basis, more often,if needed. Responsible Person(s): Recreational Therapy Director, Administrator, DON	

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F 242	Continued From page 6 Activity Interview for Daily and Activity Preferences for R230 was requested by not provided. On 7/24/14, at 9:43 a.m. registered nurse (RN)-B was interviewed and stated the activities department completes resident choices. On 7/28/14, at 3:44 p.m. the director of nursing (DON) was interviewed and stated she would expect resident preferences regarding when to get up in the morning, when to go to bed at night and the frequency and type of bathing be honored. R43 was interviewed on 7/23/14, at 10:00 a.m. and stated she was not provided the number of baths she preferred each week. R43 further stated she would like a bath twice weekly and had asked for an extra one per week, but staff said they did not have time. R43's computer-generated Admission Record dated 7/25/14, indicated diagnoses that included late effect fracture of the upper extremities, generalized osteoarthrosis, and polymyalgia rheumatica. R43's quarterly MDS dated 5/12/14, indicated R43's cognition was intact. R43's MDS further indicated R43 required extensive assistance with personal hygiene activities along with physical help in part of the bathing activity. R43's POC dated 2/17/14, indicated R43 had a self-care deficit due to history of a fractured clavicle, fibromyalgia, chronic pain, and generalized weakness and was unable to complete bathing and personal hygiene activities	F 242		

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F 242	Continued From page 7 independently. R43's POC directed interventions including staff would assist with weekly bath. A Weekly Weights and Bath Schedule (undated), indicated R43's bath day was scheduled for Monday evening. A Nursing Assistant Care Guide (undated) indicated R43 was scheduled for Monday evening. On 7/24/14, at 10:00 a.m. the activity director stated residents are asked on admission about the type of bath they would prefer, but are not asked about bathing frequency as the standard is one bath per week. The activity director further stated bathing frequency would be addressed through the nursing staff on the floor. On 7/24/14, at 1:00 p.m. nursing assistant (NA)-I stated R43 had asked for an extra bath on occasion. NA-I further stated she would always try to fit in an extra bath, but does not always have the time. NA-B stated if a resident asked for an extra bath per week, she would try hard to fit it in and if a resident kept asking regularly for an extra bath, she would get them on the schedule for more than one bath weekly. On 7/25/14, at 11:30 a.m. licensed practical nurse (LPN)-D stated residents can have a bath more than one time per week and was not aware R43 wanted a bath twice weekly. A Bath/Shower Schedule policy revised/reviewed 6/2011, indicated each resident would receive a bath or shower at least weekly. The policy further indicated if the resident would like more frequent bathing, their wishes would be followed.	F 242		
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE	F 247		9/2/14

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F 247 SS=D	Continued From page 8 ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure notification was given prior to a change in roommates for 1 of 3 residents (R222) reviewed for admission, transfer, discharge. Findings include: R22's Admission Record dated 7/11/14, identified diagnoses that included acute respiratory disorder, heart failure and ventricular tachycardia. R22's care plan dated 7/15/14, indicated R22 was alert and oriented. On 7/22/14, at 7:17 p.m. R22 stated he was not given notice before a new roommate moved in. On 7/24/14, at 12:04 p.m., the director of social service (SS)-A, stated residents were given verbal notice when they are receiving a new roommate. SS-A was unable to locate documentation of communication with R22 regarding a new roommate. The facility policy and procedure on Transfer, Room to Room dated 12/12, directed a roommate will be informed of any new transfer into his/her room. Such information will include why the transfer is being made and any information that will assist the roommate in accepting his or her new roommate.	F 247	F 247 In relation to the Right to Notice before Room/Roommate Change, it is the policy of the facility to notify residents of a room or roommate change within the facility. R22 affected by this deficient practice,will be notified of future roommates or room changes. The facility will ensure the deficient practice does not reoccur by adapting currently used, "Room-to-Room Transfer" form to reflect notification of roommate. If a patient/resident is admitting to a double room, roommate will be notified as previously practiced of incoming resident/patient. To ensure compliance with this system, audits will randomly be conducted by social services for residents who transferred rooms or had a roommate change. The Quality Assurance Performance Improvement committee will determine discontinuation of audits once policy has been deemed to be established and maintained.	

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F 247	Continued From page 9	F 247	Responsible Person(s): Social Services Director Administrator Director of Nursing	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide leisure activities to meet the individual resident's needs for 1 of 1 residents (R43) reviewed for activities. Findings include: R43's computer-generated Admission Record dated 7/25/14, indicated diagnoses that included late effect fracture of the upper extremities, generalized osteoarthrosis, and polymyalgia rheumatica. R43's quarterly Minimum Data Set (MDS) dated 5/12/14, indicated R43's cognition was intact. A Care Area Assessment (CAA) for psychological well-being dated 8/9/13, indicated R43 was not able to do usual activities due to the current situation. Another CAA for activities dated 8/12/13, indicated R43 had family visiting and providing for socialization needs.	F 248	F 248 In relation to the deficiency, Activities Meet Interest/Needs of each Resident, it is the policy of the facility to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident. To address R43□'s concerns, an interview was conducted by the Recreational Therapy Director to determine resident preferences. R43□'s desired changes have been implemented and care plan has been updated. To ensure compliance with this deficient practice for R43, there will be ongoing, weekly, 1:1 visits with resident conducted with Social Services. R43 is agreeable to making a list of concerns and sharing with	9/2/14

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F 248	Continued From page 10 A Care Conference Summary/Nursing dated 5/20/14, noted under "Expectations/Concerns" R43's family member brought R43's sewing machine to the building on 5/11/14. The Care Conference Summary further noted a discussion about R43's sewing machine had occurred in an IDT [inter-disciplinary team] meeting and was deemed as not appropriate at this time. The Care Conference Summary also indicated due to R43's limited mobility, supervision and at times assistance would be needed for R43 to use the sewing machine, and the machine was viewed as a safety hazard to R43 and others. The Care Conference Summary further indicated R43's family could bring the sewing machine in when visiting and supervise R43, and then take the machine back home at the end of the visit. R43's Plan of Care (POC) for recreational therapy, revised 5/12/14, indicated R43 had a potential for decreased level of social interaction related to a physical impairment, with a goal R43 would like to attend programs of choice, leisure independently, and continue a daily routine. R43's POC interventions were to invite to activities chosen per resident interview and offer or set up with additional leisure supplies per preference prn [as needed], such as crafts, sewing. R43 was interviewed on 7/23/14, at 9:56 a.m. and stated she asked to have her sewing machine in the facility some time in 12/2013, after the left upper extremity fracture was healed. Facility staff told her it was "unsafe" for her to operate the machine. Another time staff denied the request for sewing in her room because the room was too crowded. R43 became tearful and stated how difficult the situation had been and losing the use	F 248	Social Services to ensure compliance with deficient practice. To ensure compliance of this practice with all residents, the Recreational Therapy staff will follow-up with all residents to ensure current needs/desires are being met for activities. Additionally, Recreational Therapy staff will follow-up quarterly and as needed on resident satisfaction of current activities. Activities will continue to ask the four quality review questions at quarterly care conferences and implement interventions based on the resident/family/POA answers to these questions. Audits will be conducted weekly x4 weeks, then monthly thereafter to ensure compliance with this deficient practice. The QAPI committee will determine discontinuation date for audits once deemed compliant with current policy and determined practice(s) are sustained. Responsible Person(s) Recreational Therapy Director Administrator	

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F 248	Continued From page 11	F 248		

of her sewing machine added to the many losses experienced this past year. When asked if the risks versus benefits of independent use of the sewing machine in the room were discussed with her, R43 replied, "No." R43 further stated staff never assessed her ability to safely use the sewing machine and did not offer to indicate that space in her room could be arranged.

Licensed practical nurse (LPN)-D and the social services director (SSD) were interviewed on 7/24/14, at 9:28 a.m.. LPN-D stated R43 was upset with staff when she was told the sewing machine would not be allowed in the room. LPN-D further stated R43's previous roommate had wandering tendencies and may have been at risk for injury from the sewing machine, however, that roommate moved out some time ago. Both LPN-D and the SSD stated they did not know if R43 could safely use the sewing machine in her room or if the risks involved were discussed. Both LPN-D and the SSD mentioned an IDT meeting where R43's safety with the sewing machine had been determined, but there was no documentation of the discussion.

On 7/25/14, at approximately 10:00 a.m. R43 stated she had been sewing since she was 5 years old and knew how to handle a sewing machine. R43 further stated she did attend a sewing club meeting with several community members, twice weekly, in a facility community room. R43 stated she would like to sew when she wanted to, like she used to do when she lived at home. R43 again became tearful when talking about losing her ability to sew when she wanted.

On 7/25/14, at approximately 2:35 p.m. the director of nursing (DON) stated she did not know

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F 248	Continued From page 12 if R43 was assessed to determine safety with independent use of the sewing machine after the fracture was healed.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for medication use for 1 of 5 residents (R6) reviewed for medications. Findings include: R6's physician progress notes dated 6/19/14,	F 279	F 279 It is the policy of the facility that all residents have a comprehensive care plan that includes measurable objectives and timetables to meet a resident□s medical, nursing, and mental and psychosocial needs that are indentified in the comprehensive care plan.	9/2/14

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	245328	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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 279	Continued From page 13 indicated diagnosis of atrial fibrillation with chronic Coumadin (anticoagulant medication). The signed physician orders dated 6/18/14, included Coumadin, and the Medication Administration Record (MAR) dated 7/2014, directed Coumadin 2 milligrams (mg) daily. The laboratory test to check the Coumadin levels was ordered for 8/10/14. The previous laboratory test for Coumadin levels were collected and evaluated by the physician with changes in medication orders documented on the MAR for July 2014. R6 was observed with two small, medium purple bruises on the right arm on 7/24/14, at 8:53 a.m. R6 did not know where they bruises came from, but denied discomfort from bruising. R6's care plan revised 7/15/14, did not address Coumadin use, monitoring for bleeding, or side effects of Coumadin. The July MAR lacked monitoring for side effects and signs or symptoms of bleeding. During an interview on 7/25/14, at 3:50 p.m., the director of nursing (DON) verified Coumadin, risks and monitoring should be addressed on the care plan. The policy and procedure for anticoagulation revised 4/2013, directed staff to monitor for possible complications in individuals who are taking anticoagulant medication and manage related problems., such as excessive bruising, blood in urine, blood in sputum, or other evidence of bleeding. The policy directed staff to notify the physician before giving the next scheduled dose of the anticoagulant.	F 279	To address the deficient practice related to the development of a comprehensive care plan for medication use for R6, the care plan has been updated to reflect medication uses that pose a potential risk for adverse reactions. At this time, the care plan has been updated to reflect the use of an anticoagulant medication and monitoring initiated every shift and PRN for adverse effects of anticoagulant medications and potential symptoms of bleeding. To ensure the deficient practice does not impact other residents, all residents receiving anticoagulant medications or other medications that may have an adverse effect on the resident, will have care plans reflective of potential side effects and necessary monitoring as applicable to medication(s). To ensure compliance with this policy, all resident MARs and Care Plans will be audited to ensure medications are care planned with appropriate monitoring in place. Staff will be educated on medication care planning, side effects and monitoring. Once all the residents have been audited, monthly MAR/Care Plan audits will be conducted to ensure compliance. The Quality Assurance Performance Improvement committee will determine discontinuation of audits once policy has been deemed to be established and maintained.	

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F 279	Continued From page 14	F 279	Responsible Person(s): Director of Nursing	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care plans were revised for 2 of 22 residents (R87, R43) whose care plans were reviewed. Findings include: R87's Record of Admission updated 2/7/13, identified diagnoses that included dysphagia	F 280	F 280 In relation to the Right to Participate Planning Care □ Revise CP, the facility policy, Care Plans □ Comprehensive, states Assessments of residents are ongoing and care plans are revised as information about the resident and the resident□s condition change. For R87 and R43, care plans have been	9/2/14

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F 280	Continued From page 15 (difficulty swallowing), disorder of the esophagus, congestive heart failure, and atrial fibrillation. R87's quarterly Minimum Data Set (MDS) dated 4/30/14, indicated R87 was cognitively intact. The MDS further indicated R87 required extensive assistance of one staff for bathing, set up assistance of one staff for personal hygiene, and oversight, cues, supervision for bed mobility, transfers, ambulation, dressing and eating. The MDS also identified R87 as being at risk for falls, and had 2 or more falls since the previous MDS (1/30/14) with injury that was not major. R87's care plan dated 5/13/14, indicated R87 was unable to complete bathing, grooming or personal hygiene independently. The care plan also indicated R87 was able to perform all personal hygiene (with staff providing support as needed and encourage independence) and required staff assistance with weekly shower. The care plan indicated R87 was independent with transfers and bed mobility and could ambulate independently with walker to all destinations, On 7/25/14, at 9:06 a.m. R87 was observed during transfer from the toilet to the wheelchair. Nursing Assistant (NA)-F applied a transfer belt to R87, assisted R87 with standing up off of the toilet, provided peri care, pulled up R87's pants, and then pivoted her to the wheelchair. NA-C came into the room, and assisted NA-F with transferring R87 out of the wheelchair. R87 took a few steps with a walker and assistance of NA-C and NA-F towards the recliner before being lifted up into the recliner by NA-C and NA-F. NA-F stated R87 required more assistance with everything since a fall a week or so ago (7/13/14). On 7/25/14, at 2:18 p.m. NA-H was interviewed	F 280	updated to reflect the current level of care needed for each resident. To ensure compliance with this policy, staff will be re-educated by nursing to ensure care plans are updated as applicable. During daily clinical reviews, changes in status will be communicated and appropriate updates made by nursing to reflect current care needs of resident(s). To ensure all resident care plans are up-to-date, facility will audit all current residents to ensure compliance. To ensure compliance and maintanence with this policy, audits will be conducted monthly, then randomly thereafter. Care plans will continue to be reviewed quarterly for accuracy. The Quality Assurance Performance Improvement(QAPI) committee will determine discontinuation of audits once policy has been deemed to be established and maintained. Responsible Person(s): Director of Nursing	

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F 280	Continued From page 16 and stated R87 has required more staff assistance ever since the fall. NA-H stated R87 has pain some days, and requires assist of two staff if she is having more pain. NA-H stated there are days when R87 can even walk a few steps and can tell staff how much assistance she feels she needs. On 7/25/14 at 2:30 p.m. registered nurse (RN)-B was interviewed, and verified R87 had a change in her transfers, ambulation, and toileting, and the facility needed to revise the care plan. The facility was unable to provide a policy and procedure on revision of care plans.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide effective pain relief for 1 of 4 residents (R87) reviewed for pain. Findings include: R87's Record of Admission updated 2/7/13, identified diagnoses that included dysphagia (difficulty swallowing), disorder of the esophagus,	F 309	F 309 In relation to the deficient practice to Provide Care/Services for Highest Well Being, it is the policy of the facility to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. It is the policy of the facility	9/2/14

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F 309	Continued From page 17 congestive heart failure, and atrial fibrillation. The quarterly Minimum Data Set (MDS) dated 4/30/14, indicated R87 was cognitively intact with moderate pain, a scheduled pain medication regimen, and no PRN (as needed) pain medications. The MDS further indicated R87 received non-medication interventions for pain. The pain did not interfere with sleep at night and did not limit day-to-day activities. R87 was being at risk for falls, required extensive assistance of one staff for bathing, set up assistance of one staff for personal hygiene, and oversight, cues, supervision for bed mobility, transfers, ambulation, dressing and eating. The physician's orders dated 7/2/14, directed Norco (a narcotic analgesic medication) 5/325 milligrams (mg) 1 tablet twice a day, 1/2 tablet twice a day, and every three hours as needed for pain. The orders also included Tylenol 650 mg three times a day for pain. The Medication Administration Record (MAR) for 7/14, indicated R87 had received the PRN dose of Norco times from 7/1/14, through 7/21/14, with all but one dose documented as effective. The facility Incident Report dated 7/13/14, indicated R87 fell in the bathroom and complained of right side rib cage pain and upper thigh pain following the fall. An x-ray of the right shoulder, right hip, and pelvis were all negative for fracture. During interview on 7/23/14, at 1:44 p.m. R87 stated she had pain with no relief. R87 stated she had a fall a few weeks ago, and sustained pain in her right hip and right shoulder. R87 stated she can have pain medication when she asks for it, but it doesn't help.	F 309	to provide effective pain relief for all residents. In relation to R87, both a pain assessment and pain interview have been completed. R87 denies pain interferes with activities or sleep at this time. NP and MD continue to be involved and assist in pain management. According to R87, pain is managed at this time and resident declined changes to current pain management regimen. To prevent and ensure potential unresolved pain for other residents, pain interviews will be conducted to ensure adequate pain management and updated as indicated. To ensure this deficient practice does not re-occur, facility staff will be re-educated on the facility'□s policy for Pain Management. According to the Pain Management policy, "residents are assessed for pain by a licensed nurse upon admission/hospital return, with a change in condition, quarterly, annually and more frequently, if needed. To ensure compliance with this policy, resident interviews and audits will be conducted daily x2 weeks, then weekly x4 weeks and then monthly thereafter to ensure pain management for residents. In addition, pain management will be reviewed with care conferences to ensure effective pain control for the resident/patient.	

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F 309	Continued From page 18 R87's care plan dated 5/13/14, indicated a potential for arthritic pain to left shoulder and left thumb. The interventions included scheduled and PRN Tylenol, anticipate R87's need for pain relief, respond immediately to any complaint of pain, and evaluate the effectiveness of pain interventions at least quarterly and PRN. On 7/24/14, at 12:18 p.m. R87 was observed in her recliner chair rubbing her right shoulder area and holding her right forearm in front of her body. R87 stated her pain was, "Pretty bad." R87 further stated she had therapy earlier in the day and they rubbed something on it to help with pain but it didn't help. R87 further stated she did not sleep very well the night before because of the pain. On 7/25/14, at 2:21 p.m. nursing assistant (NA)-H was interviewed, and stated R87 told staff her pain was less in the past couple of days and is less in the evenings. On 7/25/14, at 2:30 p.m. registered nurse (RN)-B was interviewed and stated interventions included warm towels, elevating the affected area, and providing increased medication for R87's pain. RN-B stated R87 did not want any pain medications today, but went to therapy and was having increased pain at this time. On 7/25/14, at 4:16 p.m. the director of nursing (DON) was interviewed and stated the facility should be completing a pain assessment with any new report of pain. The facility policy and procedure on Pain - Clinical Protocol dated 4/13, directed nursing staff to	F 309	The Quality Assurance Performance Improvement(QAPI) committee will determine if discontinuation of audits is indicated once policy has been deemed established and maintained. Responsible Person(s): Director of Nursing	

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F 309	Continued From page 19 assess each individual for pain when there is onset of new pain or worsening of existing pain. The nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated, and the staff and the physician will also evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide nail care and/r remove facial hair for 2 of 3 residents (R6, P91) reviewed for activities of daily living (ADLs). Findings include: R6 had dirty finger nails on both hands and several long facial hairs when observed on 7/22/14, at 6:41 p.m. The quarterly Minimum Data Set (MDS) dated 4/10/14, indicated R6 had a moderate cognitive impairment, required extensive assist of one staff for personal hygiene, and had no range of motion deficits. The ADL Care Area Assessment (CAA) worksheet dated 7/22/14, indicated R6 had no functional limitations in ROM. The CAA further	F 312	F 312 In relation to ADL Care Provided For Dependent Residents, it is the policy of the facility that Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.). R91 and R6□s care plans have been updated to reflect facial hair preferences. Furthermore, care plans will be updated for all residents with facial hair to reflect preferences. As it relates to cleaning of fingernails, in addition to trimming on bath day, hands/fingernails are to be cleaned before and after meals or as noted as dirty. To ensure this deficient practice does not re-occur, staff will be re-educated on	9/2/14

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F 312	Continued From page 20 indicated R6 had little to no participation in ADLs. Staff was to assist with all ADLs and emphasize comfort. R6's ADLs care plan revised 7/15/14, indicated staff were to complete nail care with the weekly shower. The care plan lacked direction for removal of facial hair. During observations on 7/24/14, at 8:53 a.m. R6 continued to have facial hair and dirty nails on both hands. On 7/25/14, at 1:40 p.m. R6's facial hair was gone. R6 smiled and stated her chin was shaved the previous evening with her bath. R6's fingernails were not clean. During an interview on 7/25/14, at 10:48 a.m., licensed practical nurse (LPN)-D stated R6 was dependent with cares and nail care was to be done with the bath on Thursday evenings. LPN-D stated nail care shows up on the resident's screen and the staff have to sign it off. LPN-D further stated, facial hair is to be removed daily or whenever facial hair is noticed. The policy and procedure for care of fingernails/toenails revised 10/2010, directed at a minimum, nail care is provided on bath day and includes routine cleaning and regular trimming. It further directed only licensed nurses may trim the nails of diabetic residents or circulatory impairments. The policy and procedure for quality of life-dignity revised 10/2009, directed staff to groom residents as they wish to be groomed, including hair styles, nails, and facial hair.	F 312	resident preferences, refusals, nurse notification and documentation requirements. To ensure compliance, resident preferences for grooming will be care planned upon admission,updated quarterly or as needed. To ensure compliance with the facility□'s policy, observational audits of residents for grooming will be completed daily x 2 weeks, then weekly and monthly thereafter. The Quality Assurance Performance Improvment committee will determine discontinuation of audits once policy has been deemed re-established and maintained. Responsible Person(s): Director of Nursing	

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F 312	Continued From page 21	F 312		

R91's computer-generated Admission Record dated 7/25/14, indicated R91's diagnoses included infantile cerebral palsy, paralysis agitans, macular degeneration, and osteoarthrosis.

R91's quarterly MDS dated 4/13/14, indicated R91 had severe cognitive impairment and required extensive assistance with personal hygiene activities.

R91's care plan revised 7/23/14, indicated R91 had a self-care deficit in ADL's due to cerebral palsy and weakness with an inability to complete grooming and personal hygiene activities. R91's care plan directed staff to set R91 up at the sink and allow R91 to perform a grooming program independently with 5 minute checks. The care plan did not address the removal of facial hair on the weekly bath day.

A Group Sheet [Nursing Assistant Care Guide} updated 7/14/14, indicated R91 was scheduled for a bath on Monday mornings and was set up for ADL's. A Master Weekly Bath Schedule updated 7/14/14, indicated R91 was scheduled to receive a bath on Monday mornings.

During an initial resident interview on 7/23/14, at 9:09 a.m. R91 was observed to have several long (1 to 1.5 inch) white chin hairs. Upon mention of the chin hairs, R91 was observed to rub the chin area on the face. R91 stated the nursing assistants would usually offer and then remove the hairs on the weekly bath day, and R91 stated the bath day was Monday.

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F 312	Continued From page 22 On 7/24/14, at 8:01 a.m. R91 had visible chin hairs when observed wheeling around in the facility. On 7/25/14, at 8:00 a.m. registered nurse (RN)-B residents were to receive nail and face care, including hair removal on their weekly bath day schedule or more often as directed by the nursing assistant care sheets. On 7/25/14, at 8:57 a.m. nursing assistant (NA)-C stated R91 would often refuse to have facial hair removed and would get upset. NA-C further stated R91 gets a bath on Mondays and that is when the facial hairs would be removed. NA-C also stated R91 would be reapproached if removal of the facial hair was refused. NA-C further stated she would not necessarily tell the nurse if R91 was refusing cares or document the refusal. On 7/25/14, at 2:58 p.m. the director of nursing (DON) stated residents should be well groomed including the removal of facial hairs on bath day, or sooner and more often if needed.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		9/2/14

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F 314	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess, identify and provide interventions to prevent the development of a pressure ulcer for 1 of 1 residents (R230). This resulted in actual harm with the development of a large blister on the left heel for R230. Findings include: Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage II: Partial thickness Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or sero-sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. R230 was admitted to the facility on 7/15/14. R230's Admission Record dated 7/15/14, identified diagnoses that included hip joint replacement, moderate chronic kidney disease and hypertension. The Nursing Assessment completed 7/15/14, indicated R230 had skin tears, basic surgical incision/incisions, bruises or rashes, but did not identify the presence of pressure ulcers, stasis, venous or complex wounds.	F 314	F 314 In relation to Treatment/SVCS to Prevent/Heal Pressure Sores, it is the policy of the facility to implement interventions to prevent the development of pressure sores and those with a pressure sore(s) receive necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. In relation to R230, staff involved were educated to follow the plan of care and ensure implementation and documentation for potential alterations of skin integrity to prevent tissue damage and promote healing of current wound(s). Nursing staff also educated regarding the orders directed by therapy to wear the heel protection boot during ambulation, while in bed and wheelchair. Care plan updated to reflect the use of the boot while in bed. It is the policy, Pressure Ulcers/Skin Breakdown □ Clinical Protocol, of which the nursing staff and Attending Physician assess and document an individual□s significant risk factors for developing pressure ulcers. Furthermore, the facility policy for Prevention of Pressure Ulcers is integrated into a patient/resident□s plan of care as applicable to risk factors. It is the facility's standard protocol that all resident/patients have a pressure relieving mattress and w/c cushion and are turned and repositioned Q2H. Furthermore, it is	

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F 314	Continued From page 24 The physician's orders dated 7/15/14, directed bilateral below knee length stockings, remove 30 minutes every day and evening shift. The progress notes dated 7/16/14, and 7/21/14, indicated R230 refused to wear the stockings. On 7/23/14, the progress notes indicated the stockings were put on hold due to the blister on the left foot. On 7/23/14, the progress notes indicated therapy evaluated R230, and supplied a heel protection ambulation boot to use during ambulation and while in bed and wheelchair to help offload pressure. The care plan dated 7/15/14, and updated 7/22/14, directed turn every one hour while in bed, eggcrate mattress on bed, elevate heels off bed (left and right). The care plan was updated on 7/23/14, and directed left foot walking heel protector on with ambulation and when in wheelchair, physical assist of one staff and walker for ambulating to and from the bathroom, physical assist of one staff with bed mobility and transfers. The nursing assistant care guide (undated) directed to reposition every one hour when in bed, left heel protector on with ambulation and while in wheelchair, and reposition every two hours when in wheelchair. R230's skin assessment dated 7/15/14, indicated a 0.8 centimeter (cm) x 1.2 cm healing blister on the right heel. The assessment further identified R230 as at risk for skin breakdown due to potential shearing, decreased mobility and increased pain during movement. Interventions included transfers with extensive assist of two, dietician to do nutritional assessment, and weekly skin checks. On 7/21/14, the skin assessment indicated a 0.8 cm x 1.2 cm healing blister on the right heel, and skin prep was applied. The skin	F 314	the policy of the facility that the a patient/resident's plan of care is followed accordingly. To ensure others are not affected by the deficient practice, staff will re-assess residents with Braden assessment scores under 18 to ensure risk factors have been assessed and interventions to prevent ulcerations or skin breakdown have been implemented and care planned. To ensure this deficient practice does not re-occur, all staff to be re-educated by nursing on the importance of following the plan of care and to ensure accurate implementation of interventions recommended by therapy, MD, Dietician and Nursing. In addition, re-education in relation to prevention of pressure ulcers and assessing risk factors for potential skin breakdown will also be included. Nursing staff will continue to complete a head-to-toe assessment, Skin assessment, Wound Observation Tool(s), Braden Risk Assessment, and Temporary Skin Care Plan upon admission/readmission to determine risk factors and interventions. Furthermore, the admission care plans have been updated to reflect additional preventative interventions. To further ensure prevention of future deficient practices, admissions and those with a change in condition will have a thorough skin assessment conducted to	

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F 314	Continued From page 25 issue notes identified R230 was at risk due to potential shearing, decreased mobility, and increased pain during movement. Interventions included turn and toilet every two hours or as needed, transfers with extensive assistance of two, and weekly skin checks. On 7/22/14, the skin assessment indicated a 1.1 cm x 0.8 cm healing blister on the right ankle, skin prep applied. The skin assessment also identified a 11 cm x 5 cm fluid filled blister on the left inner ankle around bottom of heel, area mushy non-blanchable with surrounding redness. Interventions included skin prep applied to area, skin prep to be applied three times daily, turn and reposition every hour while in bed, elevate heels off the bed, egg crate applied on bed, see physician on Thursday, and notify dietary. On 7/22/14 R230's progress notes indicated resident found to have a large blister on left heel, see skin assessment 7/22/14. On 7/23/14, at 3:30 a.m. a progress noted indicated R230's left ankle blister had ruptured during the night, skin covering wound still intact. On 7/23/14, at 2:03 p.m. R230 was observed lying in bed. R230's bed had an egg crate mattress, the left heel was in a heel lift boot, and the right foot was directly on the bed. R230 stated she had pain in both of her feet from blisters, and was unaware of how they had occurred. R230 was observed lying in bed on 7/24/14, at 7:25 a.m.. R230's left heel was in a heel lift boot on the pillow, and the right foot was lying on the bed with a non-skid bootie. At 7:45 a.m. trained medication aide (TMA)-C and nursing assistant (NA)-E entered R230's room and stated they were going to reposition her. TMA-C and NA-E pulled R230 up in bed. NA-E left the room, and came back with a pillow which was placed under	F 314	determine risk factors for ulcerations or alterations in skin integrity. In addition, during daily clinicals, staff will continue to report skin concerns/pressure ulcers/etc. to ensure facility protocols are implemented and followed. To monitor compliance, Nursing will conduct observational audits and care plan audits of those with actual pressure ulcers or those at risk for pressure ulcers daily x2 weeks. Then observational audits will be conducted weekly x2 weeks and monthly, thereafter. The QAPI committee will determine if a discontinuation date for audits is warranted if the facility has been compliant with current policy and has been sustained. Responsible Person(s): Director of Nursing	

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F 314	Continued From page 26 R230's right foot because the right heel was was supposed to be floated. On 7/24/14, at 8:03 a.m. registered nurse (RN)-B and licensed practical nurse (LPN)-C were observed during a dressing change to the left heel. RN-B identified the area as a Stage II pressure area measuring 6 cm x 4.5 cm. When questioned, neither RN-B or LPN-C were aware of the blister on the right heel. RN-B identified the blister as a Stage II blister measuring 1 cm, and told LPN-C to place a heel lift boot on the right foot. On 7/24/14, at 12:27 p.m. R230 was observed in her room sitting in the recliner. R230's right foot was sitting on the recliner footrest, and the left foot was not in a heel lift boot. R230's left heel was placed directly on a pillow, and was not floated. On 7/25/14, at 2:09 p.m. RN-C was interviewed and stated R230 was admitted to the facility with a blister on the right foot, and later developed a blister on the left heel. RN-C stated she was unsure how the blister on the left heel developed. On 7/28/14, at 3:44 p.m. the director of nursing (DON) was interviewed, and stated the facility was unable to determine how the blister on the left heel occurred. The DON further stated she would expect that R230's heels be floated per the care plan. The facility was unable to provide a policy and procedure on pressure ulcers.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		9/2/14

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F 329	Continued From page 27 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide monitoring for potential adverse reactions to medications for 2 of 5 residents (R227, R6) reviewed for unnecessary medications. Findings include: R227's computer-generated Admission Record dated 7/25/14, indicated diagnoses that included	F 329	F 329 To address the tag, Drug Regimen is Free From Unnecessary Drugs, it is the facility□s policy for Anticoagulation □ Clinical Protocol that reads The staff and physician will monitor for possible complications in individuals being anticoagulated, and will manage related problems. As this relates to R6, monitoring for potential adverse effects has been added to the resident□s MAR	

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F 329	Continued From page 28 atrial fibrillation and mild recurrent major depressive disorder. R227's admission Minimum Data Set (MDS) dated 7/22/14, indicated moderate cognitive impairment. R227's PHQ [psychological health questionnaire] dated 7/15/14, indicated mild depression with a score of 9 out of 27. R227's Order Summary Report dated 7/18/14, directed Citalopram Hydrobromide [Celexa, antidepressant medication] 10 mg by mouth one time a day with monitoring for potential side effects. R227's Physician's Telephone Orders dated 7/21/14, directed Coumadin 1 mg by mouth one time a day. R227's Order Summary Report dated 7/18/14, did not contain any specific side effects to be monitored for use of the Coumadin. R227's care plan for psychotropic drug use dated 7/24/14, indicated R227 was receiving Celexa for depressive disorder and directed to monitor for side effects of the medication every shift. The care plan for anticoagulant therapy dated 7/24/14, indicated R227 was receiving Coumadin and directed to monitor for hemoptysis, hematuria, ecchymosis, and bleeding gums. During the survey week of 7/22/14, through 7/25/14, R227 was observed on multiple occasions and did not display any medication side effects of either the Coumadin or the Celexa. On 7/25/14, at 10:52 a.m. registered nurse (RN)-B stated side effect monitoring of medications is completed on the EMAR and the nurses progress notes would reflect	F 329	and Care Plan updated to reflect anticoagulation use, goals and interventions. To further address the use of psychoactive medications, it is the policy of the facility to monitor for potential adverse effects on the MAR and care plan the use of any psychoactive medication. In relation to R227, the MAR has been updated to reflect monitor for anticoagulation therapy and psychoactive medication use. Furthermore, R227□s care plan has been updated to reflect aforementioned medication use. To ensure compliance with monitoring and care plans, all residents receiving anticoagulant therapy and psychoactive medications will be reviewed to ensure accurate monitoring and care plans have been initiated and implemented. To ensure this deficient practice does not re-occur, staff will be re-educated to ensure facility policy is followed for monitoring and care planning as it relates to anticoagulation therapy and psychotropic medication use. Audits will be conducted among all stations to ensure compliance with policy. The QAPI committee will determine discontinuation date as it deems the facility has been compliant with current policy and determines policy has been sustained. Responsible Person(s): Director of Nursing	

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F 329	Continued From page 29 documentation if the resident was experiencing any untoward effects of a medication. RN-B confirmed R227's medical record did not address medication side effect monitoring for either the anticoagulant therapy or the antidepressant medication. On 7/25/14, at 2:54 p.m. the director of nursing (DON) stated the monitoring of side effects for medications such as an antidepressant and an anticoagulant should be completed on the EMAR. The physician progress notes dated 6/19/14, indicated R6 had a diagnosis of atrial fibrillation with chronic Coumadin (anticoagulant). The signed physician order summary dated 6/18/14, indicated R6 had an order for Coumadin, and the Medication Administration Record (MAR) dated 7/2014, indicated R6's current medication orders included Coumadin 2 milligrams (mg) daily. The laboratory test to check the Coumadin levels was ordered for 8/10/14. The previous laboratory test for Coumadin levels were collected and evaluated by the physician with changes in medication orders documented on the MAR for July 2014. R6's current diagnoses per the Order Summary Report dated 6/18/14, included palliative care, congestive heart failure, diabetes, atrial fibrillation (irregular heart rate), chronic kidney disease, hypertension (high blood pressure), edema and Alzheimer's. On 7/24/14, at 8:53 a.m. R6 was sitting in her wheelchair in her room and she was observed to have two small, medium purple bruises, one below the elbow and one above the elbow on the outer side of the right arm. R6 did not know where they bruises came from, but denied	F 329		

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F 329	Continued From page 30 discomfort from bruising. The care plan dated as printed on 7/25/14, lacked direction for monitoring potential adverse effects, including bruising, of Coumadin therapy. During an interview on 7/25/14, at 3:50 p.m., the director of nursing (DON) verified Coumadin and risks should be addressed on the care plan and monitored. The policy and procedure for anticoagulation revised 4/2013, directed staff to monitor for possible complications in individuals who are being anticoagulated and manage related problems., such as excessive bruising, blood in urine, blood in sputum, or other evidence of bleeding. The policy directed staff to notify the physician before giving the next scheduled dose of the anticoagulant.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data	F 356		9/2/14

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F 356	Continued From page 31 specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure daily posting of nurse staffing hours and to include the actual hours worked for both licensed and unlicensed staff. This had the potential to affect any of the 92 residents residing in the facility, family members, and any visitors who may have chosen to view the information. Findings include: During the initial tour of the facility on 7/22/14, at 2:51 p.m. the nurse staff posting dated 7/11/14, was observed to be located in a clear, plastic holder mounted on the wall in the hallway near the main entrance to the facility. The posted Nurse Staffing and Census Information did not include the actual hours worked for the licensed staff for the day shift, evening shift and noc [night] shift. The Nurse Staffing posting also did not denote actual hours worked for unlicensed staff	F 356	F 356 To address the deficient practice related to Posted Nurse Staffing Information, it is the policy of the facility to post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. Upon notification of incorrect posting, facility updated current posting to reflect requirements of the policy. The Staffing Coordinator was re-educated to the current policy. To ensure this deficient practice does not re-occur, an internal policy will be written to identify the current process and who is responsible for updating of the posted information should the Staffing Coordinator be out of the building. Nursing staff to be re-educated on current policy and requirements.	

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F 356	Continued From page 32 on the day and noc shifts. On 7/23/14, at 3:04 p.m. the director of nursing (DON) stated the nurse staff posting should be put up daily. The DON further stated the staffing coordinator was responsible for putting the information together and posting it on the wall. The DON also stated she was not sure what information was required to be on the nurse staff posting. On 7/23/14, at 5:30 p.m. the staffing coordinator (SC) stated she did not know why the nurse staffing posting for 7/11/14, was on the wall. The SC further stated she usually puts the posting up daily or one of the health information coordinators (HIC) will put the new posting up in the SC's absence. The copies of the nurse staffing posting for the month of 7/2014, included all but three days. The facility's policy entitled Posting Direct Care Daily Staffing Numbers revised 8/2006, indicated the facility would post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. The policy further directed within 2 hours at the beginning of each shift, the shift supervisor would compute the number of direct care staff and complete the Nursing Staff Directly Responsible for Resident Care form. The policy also directed this form would be dated, the census would be recorded, and the information posted. The policy also indicated this form would contain the actual time worked during each shift for each category and type of nursing staff.	F 356	Compliance with this practice will be monitored with daily audits to ensure the Posted Nurse Staffing Information is correct and up-to-date x 1 week, monthly, then randomly. The QAPI committee will determine discontinuation date as it deems the facility has been compliant with current policy and determined as sustained. Responsible Person(s): Director of Nursing	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		9/2/14

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F 364	Continued From page 33 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Surveyor: SETTERGREN, KIMBERLY Based on observation, interview, and document review, the facility failed to ensure food was palatable and served at acceptable temperatures. This had the potential to affect 91 of 92 residents in the facility. Findings include: During a tour of the kitchen on 7/22/14, at 2:45 p.m. The director of dietary services stated food temperatures were checked when the food comes out of the oven and at the steam table at point of service. During an interview on 7/23/2014, at 1:46 p.m. R87 stated she does not like the food and that it is often cold. R87 stated the food must be sent back to be warmed up most of the time. R87's Minimum Data Set (MDS) dated 4/30/14, indicated she was cognitively intact, is able to communicate needs, and feeds herself with supervision. R87 received a mechanically altered and therapeutic diet. During an interview on 7/23/2014, at 10:20:40 a.m. R43 stated the meat is horrible, cold and	F 364	F 364 To address the deficient practice related to Nutritive Value/Appear, Palatable/Prefer Temp, it is the policy of the facility and New Horizon Foods to prepare food that conserves the nutritive value, flavor, appearance, and that food is palatable, attractive and at the proper temperature. To remediate the current deficient practice, the Dietary Aide (DA)in the TCU/Martha□s House kitchen will fill the steam table and turn it on by 7:00am for breakfast, 11:15am for lunch and 4:15pm for supper. The steam table in the main kitchen will be filled and turn on no later than 5:30am by the A.M. cook. The steam table will remain filled and turned on until after the service of the noon meal has ended. The P.M. cook will fill and turn on the steam table by 4:00 P.M.. The A.M. and P.M. cooks will make sure food is held at the appropriate temperature above 140 degrees Fahrenheit or below 41 degrees Fahrenheit. To ensure temperature compliance and monitoring, the A.M. and P.M. cooks will take and record the temperatures of the	

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F 364	Continued From page 34 hard, flavorless. The quarterly Minimum Data Set (MDS) dated 5/12/14, indicated R43 is cognitively intact, is able to communicate needs, and feeds herself with supervision. R43's care plan revised on 5/8/14, indicated she received a therapeutic low salt diet. On 7/24/14, at 11:35 a.m. during observations of food preparation for lunch in the main kitchen, temperatures were taken of the food immediately after removing it from the oven, and it was placed in a steam table for holding in the kitchen. At 11:50 a.m., pans of food were taken from the steam table and put on an open metal cart and moved, in bulk, to the kitchen that served the transitional care unit (TCU) and Martha's House. The hot food was placed in the steam table in the unit kitchen. At 12:00 p.m., dietary aide-A took temperatures of the food in the TCU/Martha's House kitchen as food was placed in the steam table. Meatloaf was 190 degrees. Scalloped potatoes were 176 degrees. Pork Chops were 140 degrees and were sent back to be warmed, but they never returned. Squash was 158 degrees. Mashed Potatoes were 150 degrees. Vegetables were 160 degrees. Gravy was 150 degrees. Puree vegetables were 140 degrees. Ground beef was 120 degrees and was sent back to be warmed. When it was returned, the temperature was retaken and was 148 degrees, so was sent back again. At 12:35 p.m., it was returned and the temperature was 175 degrees. Gluten free pork was 140, and was sent back to be warmed. The temperature was 154 degrees.	F 364	food for the TCU/Martha□s Kitchen before it is placed in an insulated hot box for transport. It is the responsibility of the cooks to ensure the food is at the appropriate temperature prior to transport out of the kitchen. Immediately upon arrival to the TCU/Martha□s House kitchenette, the DA will place the food into the hot steam table or into the cooler for cold items. The DA will leave foil on the food pans and cover the steam table with the well lids. Prior to service, the DA will take and record the temperatures of the food. Any food that is not at the correct temperature will immediately be sent back to the kitchen to be re-heated and delivered back to the unit in the insulated hot box for return to the TCU/Martha□s House Kitchenette. To further ensure compliance with food temperatures, the temperatures will be recorded at every meal on the temperature log. The temperature log will be reviewed by the Food Service Director (FSD, Assistant FSD or designee daily. All dietary staff to be re-educated by FSD on temperature regulations for all foods and temperature logs to ensure compliance. To further extend compliance, facility to order improved transport carts to ensure temperature compliance with foods/drinks delivered to rooms.	

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	245328	A. BUILDING _____ B. WING _____	07/25/2014

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F 364	Continued From page 35 Pureed meatloaf was 138 degrees and was sent back to be re-warmed. The temperature was 150 degrees, so was sent back again. When it returned, it was 160 degrees. The foods were brought back to be warmed and returned by the director of dietary services. He reported the holding steam table in the kitchen had not been turned up all the way, so the food did not stay warm enough. The warmest temperatures were recorded on the food temperature sheet. At 12:15 p.m., dietary aide (DA)-B served prepared plates of food and handed them to staff via two doors, one for Martha's House and another for the TCU. The plates for the TCU were covered with an insulated lid, put on a tray on an open metal cart, and taken to the TCU by DA-A. At 12:43 p.m., the last tray was prepared for the TCU. A test tray was prepared and food temperatures were as follows: The meatloaf was 160 degrees, scalloped potatoes were 146 degrees, and the carrots were 118 degrees. The last two trays and the test tray were brought to the TCU on the open metal cart by DA-A, who left the cart by the dining area across from the nurse's desk. Two nursing assistants came to serve the trays after being told by the nurse. At 12:53 p.m., after the two resident trays were delivered, DA-A took the temperatures of the test tray foods upon request. The meatloaf was 126 degrees, the scalloped potatoes were 131 degrees, and the carrots were 110 degrees. The food was sampled after the temperatures were taken. The meatloaf was lukewarm, had a tallow-like taste, had a gooey texture that stuck to the roof of the mouth and left a fatty aftertaste.	F 364	Responsible Person(s): Food Service Director or Designee Administrator	

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F 364	Continued From page 36 The carrots were also lukewarm. The policy and procedure for food temperatures dated 2010, directed the temperatures of all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit (F). The policy further directed temperatures should be taken periodically to ensure hot foods stay above 135 degrees F and cold foods stay below 41 degrees during portioning, transporting, and delivery until received by the individual recipient. The policy also indicated if food transportation time is extensive, food should be transported using a method that maintains temperatures.	F 364		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431		9/2/14

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F 431	Continued From page 37 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were labeled correctly for frequency of dosing for 2 of 9 residents (R92, R12) who were observed during medication administration. Findings include: R92 was observed during medication pass on 7/24/14, at 12:28 p.m. Licensed practical nurse (LPN)-B was observed to administer Tramadol [a strong pain medication] to R92. The medication label for the Tramadol was observed to contain directions of 25 mg by mouth every 6 hours. LPN-B confirmed R92's electronic Medication Administration Record (EMAR) dated 7/2014, directed Tramadol 25 mg by mouth three times a day. R92's Physician's Telephone Order dated 5/21/14, directed to increase R92's Ultram [another name for the Tramadol pain medication] to 50 mg po [by mouth] tid [three times daily].	F 431	F 431 To address the deficient practice related to Drug Records, Label/Store Drugs & Biologicals, it is the policy of the facility to ensure drugs and biological used in the facility are labeled in accordance with professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. As this deficient practice relates to R92 and R12, the medication orders were clarified, the pharmacy was notified and direction change stickers were applied to the current medication cards until a corrected medication card was received from the pharmacy with accurate labeling. To ensure this deficient practice does not impact other residents, all medications will be audited to ensure accuracy of labeling and administration.	

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F 431	Continued From page 38 On 7/25/14, at approximately 12:00 p.m. registered nurse (RN)-C stated medication labels and the EMAR along with the physician's order need to match. RN-C further stated when a medication dose or dosing schedule change, the nurse would need to apply a sticker on the medication bottle or container alerting staff to the order change. RN-C confirmed R92's Tramadol order was incorrectly labeled on both the EMAR and the medication container. RN-C verified R92's Tramadol order would need to be clarified and a new label obtained from the pharmacy. R12 was observed during medication administration on 7/25/14, at 8:35 a.m. Trained medication assistant (TMA)-B was observed to administer Arnica [an herbal supplement] to R12. The medication label for the Arnica was observed to contain directions of one tablet by mouth daily. TMA-B confirmed R12's EMAR dated 7/2014, directed Arnica one tablet three times a day. R12's Physician's Orders dated 12/28/13, directed Arnica one tablet by mouth three times daily. On 7/25/14, at approximately 9:00 a.m. LPN-D stated the pharmacy should change medication labels when found incorrect as ordered by the physician. LPN-D further stated R12's admission records from the hospital indicated R12 was to receive the Arnica three times daily. On 7/25/14, at approximately 3:00 p.m. the director of nursing stated residents' medications with incorrect labels should be sent back to the pharmacy for correction and confirmed medication labels, physician orders, and EMAR information should all be consistent.	F 431	To facilitate compliance and ensure this deficient practice does not re-occur, nursing staff will be re-educated on our current policy for "Administering Medications". In addition, audits will be conducted daily for 1 week, then weekly x4, and monthly thereafter to ensure compliance with medication labeling and administration. The QAPI committee will determine discontinuation date as it deems the facility has been compliant with current policy and determined, sustained. Responsible Person(s): Director of Nursing	

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F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		9/2/14

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F 441	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement contact precautions for 1 of 1 residents (R163) diagnosed with clostridium-difficile (C-Diff) infection. This had the potential to affect all 92 residents in the facility. Findings include: R163's Admission Record dated 6/20/14, identified a diagnosis of C-Diff (a bacterium that causes inflammation of the colon resulting in symptoms that include watery diarrhea, fever, loss of appetite, nausea, abdominal pain/tenderness). R163's care plan dated 6/20/14, did not address bowel continence or C-Diff. An isolation cart was outside of R163's room, but there was no signage to alert staff/visitors to utilize precautions. On 7/24/14, at 12:37 p.m. housekeeper (H)-A was interviewed. H-A stated R163's room is cleaned with a bleach cleaner. H-A stated when she cleans the room she wears gloves, but not a gown. H-A said gowning is up to each individual housekeeper, they can take whatever precautions they would like when cleaning a room with C-Diff. On 7/24/14, at 12:41 p.m. licensed practical nurse (LPN)-B was observed to enter R163's room, administer insulin, and leave the room. LPN-B did not wash her hands upon entering the room, did not don gloves or personal protective equipment, and did not wash her hands when she left the room. At 1:03 p.m. LPN-B entered R163's room to administer medications. LPN-B did not wash her hands upon entering the room, did not don	F 441	F 441 To address the deficient practice related to Infection Control, Prevent Spread, Linens, it is the policy of the facility that adherence to the Infection Control Program is followed at all times to provide a safe, sanitary, comfortable environment that prevents the development and transmission of disease and infection. Furthermore, as it relates specifically to C.Difficile, it is the policy of the facility to initiate Isolation Precautions. To ensure immediate compliance with the care of R163 and preventing the spread of a communicable disease, appropriate signage placed outside door. Signage had been on the door prior, but noted to be absent at the time of survey. No further cases of C-Diff identified in the building. To ensure compliance with this deficient practice, all staff will be re-educated to the facility□'s Infection Control Program and policies related to Isolation Precautions. Staff involved with care of R163 immediately re-educated to current policies. Furthermore, general standards of practice to be reviewed to ensure washing of hands before entering and when leaving a resident/patient room. Observational audits will be conducted by nursing to ensure proper infection is being followed daily x2 weeks, then weekly and monthly thereafter. In addition, chart audits will be completed for new admits with a communicable disease for one	

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F 441	Continued From page 41 gloves or personal protective equipment, and did not wash her hands when she left the room. At 1:04 p.m. LPN-B stated R163 has C-Diff, and she is both continent and incontinent of bowel. LPN-B stated she does not gown or glove when entering R163's room unless she is doing personal cares. LPN-B verified no hand hygiene prior to entering or leaving room. On 7/24/14, at 12:47 p.m. nursing assistant (NA)-D entered R163's room. NA-D did not wash her hands upon entering the room, did not don gloves or personal protective equipment, and did not wash her hands when she left the room. NA-D was interviewed at 12:48 p.m. and stated she would gown and glove if she was doing personal cares. NA-D stated R163 was continent of bowel most of the time. NA-D further stated she brought R163 a glass of juice and brought her a blanket, and she did not need to wash her hands when entering and leaving the room because she was not providing personal cares. On 7/25/14, at 9:57 a.m. the director of nursing (DON) was interviewed and verified R163 had active C-Diff. The DON stated the facility should provide signs cueing staff/visitors prior to entering R163's room. the DON further stated staff does not need to glove if they are not providing cares, but they do need to wash hands upon entering and prior to leaving R163's room. The Centers for Disease Control has issued the following precautions be used for patients with C-Diff: use Contact Precautions: for patients with known or suspected C-Diff infection: place these patients in private rooms. If private rooms are not available, these patients can be placed in rooms (cohorted) with other patients with C-Diff	F 441	month to ensure policies are followed and interventions placed. Residents currently on Isolation Precautions will be audited to ensure compliance with Infection Control Program. Facility (DON) to continue current infection control log for monitoring, trending and prevention purposes. Furthermore, a checklist will be initiated by nursing for residents/patients with communicable disease. The QAPI committee will determine discontinuation date once deemed compliant with current policy and determine practice(s) have been sustained. Responsible Person(s): Director of Nursing	

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F 441	Continued From page 42 infection. Use gloves when entering patients' rooms and during patient care. Perform Hand Hygiene after removing gloves. Use gowns when entering patient's rooms and during patient care. The facility policy and procedure on C-Diff Protocol undated, directs use of gloves when entering resident's rooms for direct care contact or environmental contact, and to use gowns if soiling likely (resident or environmental soiling).	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident rooms were maintained in a sanitary homelike manner for 19 of 92 residents (residing in rooms 123, 137, 110, 192, 111, 182, 130, 193, 121, 194, 153, 117, 120, 138, 122, 113, 170) related to urine odors, soiled toilets, dusty vents, scratched, chipped and marred walls, doors, floors and furniture. The Martha's House unit had a soiled fire extinguisher door and scraped walls and a vent and the floor in the kitchen were soiled. In addition, the kitchen floors, vents and food storage areas were not clean. Findings include: During the environmental tour on 7/25/14, at	F 465	F 465 In relation to the deficient practice of providing a Safe/Functional/Sanitary/Comfortable Environment (Long Term Care Facilities), it is the policy of the facility to provide the aforementioned environment. It is our duty at Ecumen Parmly Lifepointes, to ensure resident rooms are well maintained and in a sanitary homelike manner. The wood door in the following rooms 137, 192,182,193,121,153,117,138,122,and 170 will be repaired with wood putty, sanded and resealed by Environmental Services.	9/2/14

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F 465	Continued From page 43 10:00 a.m. with the environmental services director (ESD) and the administrator the following was noted: In room 123, the bathroom smelled strongly of urine and the toilet riser had a dark brown substance on the inside rim. In room 137, the entry door had a long scratch across most of the door near the handle. In room 110, the bathroom ceiling vent was dusty. In room 192, the bathroom door was chipped exposing rough wood and the door frame was scratched. In room 111, ceiling vent in the bathroom was dusty. In room 182, the bedroom and bathroom door frames had the paint scratched off and both doors had areas of wood missing exposing rough wood. In room 130, the floor tile was chipped and cracked. Molding was missing near the dresser. Knobs were missing from the dresser. In the bathroom shower the floor tiles had the glue left from the nonskid tape and was black in color. In room 193, the floor tile was chipped and cracked. The paint on the door frame was scratched. The bathroom door was chipped exposing rough wood and the bathroom ceiling vent was dusty. In room 121, the bathroom shower floor tiles had the glue left from the nonskid tape and was black	F 465	To ensure damage is repaired in a timely manner, all resident doors will be checked and audited weekly for 30 days. After the 30-days is complete, a bi-weekly door check will be completed for 1 month by environmental services. The checks have been added to the TELS program with a monthly reminder checklist. The repairs are currently in progress and will be completed by 9/2/14. The door frames for resident rooms 192, 182,193, 194, 117, 120, 113,and 170 will be repainted with enamel paint to rid the frames of chips and scratches and to ensure a solid smoothe surface. To ensure that damage is repaired in a timely manner as it relates to chipped paint and scratches on the door frames, all resident doors will be checked and audited weekly for 30 days. After the 30-days, a bi-weekly door check will be put into place for one month and thereafter, the facility's TELS program will provide a monthly reminder checklist. The repairs are currently in progress and will be completed by 9/2/14. The resident bathroom in room 123 was reported with a strong urine smell. Environmental Services were able to use proper chemicals to clean the tile and grout in the entire bathroom which stopped the odor. The facility Tels program was updated to reflect aforementioned cleaning task for all resident bathrooms. If an odor is noted in the future this same procedure will be	

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F 465	Continued From page 44 in color. The bathroom door was marred. In room 194, the wall behind the easy chair was scratched and the plastic molding covering wires was broken at the bottom exposing the wires. The room and bathroom door frames and wall corner near the closet were scratched, chipped and the paint was missing . In room 153, the bathroom door was marred and scratched and the plastic covering on the bottom of the door was coming off. The room door at the bottom was scratched and gouged. In room 117, the bathroom ceiling vent was dusty, the toilet had dark stains and the paper towel dispenser in the bathroom was rusty on the top. The door frame and door was badly scrapped and chipped. The top of the bedside stand was scratched. In room 120, the bathroom door frame paint was chipped and the toilet bowl was stained and dirty. In room 138, the wooden closet door was scratched exposing rough wood. In room 122, the entry door was marred and gouged on the inside and lower edge exposing rough wood. In room 113, the bathroom ceiling vent was dusty and the bathroom door frame had chipped paint. In room 170, the bathroom door was scraped exposing rough wood. The bathroom door frame was scratched and had missing paint. The veneer on the room door had a long crack and was lifted up and on the edge of the door the veneer was	F 465	followed. The following resident bath rooms 110,111,193,117,113 that were found with dust in the exhaust vents. The vents have been cleaned are currently dust free. The facility has a daily checklist that housekeepers use to ensure removal of dust. Cleaning of exhaust vents has been initiated on the facility Tels program as a daily task to be completed. A weekly follow up will be completed by the Environmental Services Director for 30 days. After 30 days, the Environmental Servics Director will do a bi-weekly follow up for 30 days, then a monthly check. In relation to the vent in the dry food storage room with dust and dirt, the vent has been cleaned. Dietary Services are unable to properly clean an area of the kitchen, a maintenance request will be completed for assistance. It is the policy of the facility and the responsibility of Dietary Services to ensure kitchens are maintained and kept clean. To ensure dietary services cleaning schedules are followed, re-education of the expectations and current polcies will be completed by Food Service Director. In room 123, the toilet riser was noticed having a dark brown substance on the inside rim. The Environmental Services Director, completed a follow up 8/14/14, and did not find any trace of brown substance on the inside rim of the riser.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 45 loose and covered with white paper tape. On the Martha's House unit, the wall was scraped behind the recliners. The wall was scraped on the wall on each side of the unit kitchen door. The door to the fire extinguisher near the unit kitchen had a white substance on the window and the metal frame. On 7/25/14, at 11:00 a.m. the ESD stated maintenance does a daily walk through. The facility used the TELS system (a computerized building management system) to direct them on what to look at either daily, weekly or monthly. The ESD stated each unit had request slips to fill out for repair needs and these were checked at least daily . On 7/22/14, at 2:45 p.m. the vent in the dry food storage room was dusty and dirty. The vent above the three compartment sink was dirty and dusty. The floor in the kitchen was dirty and had dark dirty build up under the front of the stove and oven, and dirty white white build up under the sinks and the ice machine. Cook-A stated the floors are cleaned and swept twice daily. The director of dietary services (DDS) stated maintenance cleans the vent monthly and installed a new one about three months ago. A cleaning schedule was hung up in the kitchen. The cook-A explained that tasks are completed weekly or daily, as indicated. Some of the tasks had initials on them, and most did not. The cook-A verified the tasks are to be initialed when they are completed. When asked if they were not completed if they were not initialed, cook-A verified they were either not done or they forgot to sign them off when they completed the task, but could not determine if the task was completed.	F 465	To ensure this deficient practice does not reoccur, a task to check of toilet risers has been added to the TELS program and to be completed daily by housekeeping. A weekly follow up will be completed by the Environmental Services Director for 30 days. After 30 days, the Environmental Servics Director will do a bi-weekly follow up for 30 days, then a monthly check. In relation to resident room 130, a floor tile was chipped and cracked. The tile has been replaced. There was a small piece of molding missing near the dresser that has been replaced. The knobs on the dresser were replaced. The nonskid tape residue that was on the floor in the shower area was removed and cleaned on 8/14/14. In relation to resident room 193, there was a chipped and cracked floor tile that was replaced on 8/14/14. In relation to resident bathroom 121, there was residue from the glue of the nonskid tape, this was removed and cleaned on 8/14/14. In relation to resident room 194, there were a couple of scratches on the walls that were repaired and repainted on 8/18/14. There was a glued piece of wire guard on the wall with a one-inch crack. The piece was replaced and the wires are covered and secure as of 8/18/14. In relation to Resident room 117,the night stand had a very small scratch on the top	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 465	Continued From page 46 The cook-A stated they were working on an additional cleaning list and had a designated staff to work on this list. On 7/24/14, at 1:00 p.m. The floors remained dirty with build-up under the front of the stove and oven, ice machine, and sinks. The DDS stated the floor under the ice machine was just cleaned and delimed by maintenance, and the lime build-up is difficult to remove. The director of dietary services stated the floor under the stove and oven is years of build-up and stated they do deep cleaning twice/year, and daily sweeping and mopping of floors. He stated they do weekly cleaning but did not recall if the floors were on the weekly cleaning schedule. On 7/24/14, at 1:15 p.m. the wall vent above the sinks remained dusty and dirty. When it was pointed out that the dust and dirt from the vent is above the clean dishes, the DDS stated the vent may need to be cleaned more often. He verified the vent was an intake vent and that air flows in, and not out over the dishes. The weekly and daily cleaning schedules list sweeping and mopping the floors on the daily schedule. The current cleaning schedule was requested and not provided. The policy and procedure for sanitation of dining and food service areas dated 2010, directed a cleaning schedule will be posted for all cleaning tasks, and staff will initial the tasks as completed.	F 465	of it. The scratch will be repaired with wood putty and resealed 8/19/14. The paper towel dispenser in the bathroom has a small area of rust on it. The dispenser will be taken off the wall, sanded, repainted, cleaned, and put back in place by 8/19/14. The toilet was noticed with dark stains in the bowl area. The toilet was hand scrubbed with magic eraser and all stains were released on 8/15/14. The facility has a daily check list that housekeepers use to ensure that the aforementioned areas are monitored and addressed. In addition, the facility Tels program has been updated to reflect additional daily tasks. The Enviornmental Services Director (ESD) will do a weekly follow up for 30 days. After 30 days, the ESD will do a biweekly follow up for 30 days and then monthly thereafter. In relation to the resident's bathroom in 120, had an unreleaseable stain in the bowl of the toilet. The toilet will be replaced with a new one by 8/26/14. In relation to resident room 170, the veneer on the room door was scratched and coming loose. The door was taken off the hinges and brought to the maintenance shop. The veneer of the door has been re-glued and sealed. The door was replaced back on the hinges and works correctly and is in good working condition. To ensure this deficient practice does not	

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	245328	A. BUILDING _____ B. WING _____	07/25/2014

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F 465	Continued From page 47	F 465	re-occur, the facility Tels program has been updated to reflect additional daily tasks. The Enviornmental Services Director (ESD) will do a weekly follow up for 30 days. After 30 days, the ESD will do a biweekly follow up for 30 days and then monthly thereafter. Responsible Person(s): Food Service Director Environmental Services Director Administrator	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/23/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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K 000	INITIAL COMMENTS FIRE SAFETY Building #1 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey The Margaret Parmley Residence was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Margaret Parmley Residence is a 1-story building with a no basement. The building was constructed in 1972, construction Type II(111) with an addition, in 1999, construction Type II(111). Two assisted living buildings are connected and properly fire separated. Therefore, the facility was inspected as two different buildings. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 101 beds and had a census of 98 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**07/23/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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K 000	INITIAL COMMENTS FIRE SAFETY Buidling #2 A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, The Margaret S. Parmly Residence was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. This facility will be surveyed as two separate buildings. The 2007 addition is a 2-story building with no basement and was determined to be of Type II(111) construction. The upper floor has 12 resident rooms, and the lower level has a pool and therapy functions. It is properly separated from the original building and an assisted living facility on both levels. The building is fully sprinkler protected. The facility has a fire alarm system, with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that are interconnect with each other and is transmit to the nurses station. The facility has a licensed capacity of 101 beds and had a census of 98 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is met.	K 000		

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

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**07/23/2014**

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