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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GK88

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**
2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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 **10/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 10/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245387

November 4, 2015

Ms. Mary Hamer, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, MN 55411

Dear Ms. Hamer:

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 October 10, 2015 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

October 30, 2015

Ms. Mary Hamer, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387025

Dear Ms. Hamer:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On September 15, 2015, This Department recommended to the Centers for Medicare and Medicaid Services (CMS), CMS concurred with our recommendation and authorized this Department to notify you of the following:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

Also, in our letter of September 15, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 10, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 10, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 9, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 12, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 9, 2015. We presumed, based on your plan of correction, that your

facility had corrected these deficiencies as of October 10, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 9, 2015, as of October 10, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 10, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 15, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 10, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 10, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 10, 2015, is to be rescinded.

In our letter of October 15, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 10, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	10/12/2015

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	**10/10/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GD/kfd	10/30/2015	32982	10/12/2015
Reviewed By CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/10/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GK88

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**
2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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 **09/09/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (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
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 09/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 15, 2015

Ms. Mary Hamer, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387025

Dear Ms. Hamer:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On July 31, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 9, 2015, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2015.
Based on our visit we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 10, 2015. The deficiency not corrected is as follows:

F0333 -- S/S: D -- 483.25(m)(2) -- Residents Free Of Significant Med Errors

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

- State Monitoring effective September 20, 2015. (42 CFR 488.422)

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

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

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, St Olaf Residence is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 10, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

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,

- Include electronic acknowledgement signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.
If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	R 09/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

(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 St. Olaf Residence is a Special Focus Facility (SFF) and a post visit certification survey was conducted on September 8 through September 9, 2015. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 333} SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R20) was free of insulin medication errors. Findings include: R20's annual Minimum Data Set (MDS) dated 8/22/15, indicated R20 was cognitively intact, and required assistance in all activities of daily living (ADLs) except eating. Diagnosis identified on	{F 333}	St Olaf Residence, Inc. (the ¿Facility¿) Plan of Correction is a written credible assertion of substantial compliance with the Federal and State requirements for nursing facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medicaid programs. Please note that nothing set forth in this document is to be or should be construed	10/10/15

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

Electronically Signed | 9/23/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	R 09/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

(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 333}	Continued From page 1 MDS included but not limited to diabetes. The Physician's Order dated 8/14/15, directed staff to administer Lantus Solostar insulin (medication used to control blood sugar) pen 100 unit(U)/ml (3 ml) 60 units twice daily. R20 had an order for Novolog Flexpen insulin 100 U/ml give 20 units every am. R20 also had a sliding scale insulin order dated 8/14/15. The order read: "Novolog Flexpen insulin 100 units/ml 4 TIMES BG [blood glucose] 200-250=2U, 251-300=4U, 301-350=6U, 351-400=8U, 401-450=10U, >450=CALL NP NO AT BEDTIME INSULIN IF BS [blood sugar] GREATER THAN 400 Blood sugar was 218." During observation on 9/9/15, at 8:12 a.m. of insulin administration, licensed practical nurse (LPN)-B was observed to prepare R20's insulin. LPN-B did not wipe top of Lantus Solostar or Novolog FlexPen with alcohol prior to attaching needle. LPN-B did not prime Lantus Solostar or Novolog FlexPen prior to insulin administration. LPN-B dialed up 60 units of Lantus and 22 units of Novolog. At 8:16 a.m. LPN-B gave both injections in the back of R20's right arm. During interview immediately after administering insulin LPN-B stated she had been observed doing insulins by a staff RN since last survey. LPN-B was unaware of mistakes made. Review of the Treatment Medication Record for September 2015 indicated R20 had blood sugar results that were in the 180 to 250 range. During interview on 9/9/15, at 12:05 p.m. the director of nurses (DON) stated, "You have to clean the top of the [insulin] pens before putting on a sterile needle on them, same as you have to	{F 333}	to be an admission by the Facility or employee of Facility, of the validity or accuracy of any of the deficiencies cited by DHHS Centers for Medicare and Medicaid Services relative to the survey, certification and enforcement effort at issue. Further, please note that any and all documents transmitted or otherwise provided by Facility in relation to this Plan of Correction, as well as any and all other communications in writing or otherwise by or on behalf of Facility are and shall be construed to be WITHOUT PREJUDICE to the rights, remedies, claims, defenses of Facility, at law and/or in equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Facility. F333: Resident #20 is receiving insulin correctly as ordered by the physician. Other residents who have physician orders for insulin are receiving the insulin correctly as ordered. Licensed nurses have been educated regarding facility expectation for the accurate administration of insulin using the proper technique to include wiping the top (rubber seal) of the insulin pen prior to inserting the sterile needle; and regarding priming the insulin pen with 2 units of insulin prior to each administration or as directed by the manufacturer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	R 09/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

(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 333}	Continued From page 2 wipe off a vial of insulin. I expect them to prime the pens before they give insulin; otherwise the resident loses two units." R20 did not receive the correct physician ordered insulin as the nurse did not prime the pen before administration. During interview on 9/9/15, at 1:25 p.m. DON stated, "There is no competency for LPN-B in (employee) file." The St. Olaf Residency Inc. Survey 2015 three ring binder was reviewed on 9/8/15, for copies of competencies for all licensed nurses related to insulin administration as stated in facility POC. No copies were located. Facility was asked to provide competencies for review. On 9/9/15, there were three competencies for insulin administration in the three ring binder. Competencies were all dated 9/8/15. There was not a competency test for LPN-B in three ring binder. The undated Insulin Administration Observation Audit Form did not address insulin administered via FlexPen or Solostar pen. It only addressed the vials of insulin. Policy requested for administration of insulin by pen. The package insert for Lantus SoloStar insulin by Dispensing Solutions, Inc. revised on November 2013, directed the provider/consumer to: "...Step 2. Attach the needle Always use new sterile needle for each injecton. This helps prevent contamination and potential needle blocks. A. Wipe the rubber seal with alcohol."...	{F 333}	Process of using insulin pen has been added as an addendum to the insulin administration policy. Licensed nurses have had observational audits of insulin administration completed. DON or designee will continue random observational audits to monitor compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	R 09/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

(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 333}	Continued From page 3 Step 3. Perform a Safety test Always perform the safety test before each injection. Performing the safety test ensures you get an accurate dose by: *ensuring the pen and needle work properly * removing air bubbles A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip."	{F 333}		

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
245387	A. Building B. Wing	9/9/2015

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **08/19/2015**
ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/19/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/19/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/19/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **08/19/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/19/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	09/15/2015	31223	09/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245387	A. Building B. Wing	9/9/2015

Name of Facility	Street Address, City, State, Zip Code
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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 **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/19/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/19/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/19/2015**
ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **08/19/2015**				

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/10/2015	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GK88

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00260

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245387**
2.STATE VENDOR OR MEDICAID NO.
(L2) **492242500**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST OLAF RESIDENCE**
(L4) **2912 FREMONT AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55411**

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 **07/10/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (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
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 08/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/21/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 31, 2015

Ms. Mary Hamer, Administrator
St Olaf Residence
2912 Fremont Avenue North
Minneapolis, Minnesota 55411

RE: Project Number S5387025

Dear Ms. Hamer:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On July 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<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;

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 August 19, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 10, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

PRINTED: 08/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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 St. Olaf Residence is a Special Focus Facility (SFF) and a certification survey was conducted on July 6 through July 9, 2015. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	**F157** • **Resident # 20 physician has been notified and care plan has been updated related to her stage two pressure ulcer.** • **Any residents who experiences a change in condition without physician notification has the potential to be affected by this practice.** • **All residents with skin impairment issues have had care plans reviewed and interventions are in place.**	

poc accepted eStrantlo 8/13/15

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

Mary Ann Hamer Executive Director 8-13-15

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician was notified of a Stage 2 pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) for 1 of 2 residents (R20). Findings include: The facility failed to notify the physician/provider of R20's self-imposed 44 day bed rest, failed to identify and assess a new pressure ulcer risk, and failed to add interventions to the plan of care to reduce the risk of pressure ulcer development. R20 was obese and had a pressure reduction mattress, but not a pressure relief mattress on the bed. On 7/8/15, at 9:57 a.m. nursing assistant (NA)-A was observed providing bathing cares to R20. R20 told NA-A to go easy as the terry cloth tears	F 157	• **LN educated on notification of Physician/NP for changes in condition and proper documentation of their notification.** • **DON/ Designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015** RECEIVED AUG 13 2015	

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F 157	Continued From page 2 her skin. - On 7/8/15, at 10:17 a.m. R20 was rolled to the left, her back was red with creases from clothing/sheets, and appeared to have a macular rash that extended from the high thoracic area to low lumbar area, the macular rash was worse on left then on right. NA-A noticed the bed was wet in the peri area; and scrubbed the mattress. The NA-A continued with the bath. R20 had purple discoloration (in varying shades) from upper thighs (above gluteal fold) and included the buttocks. NA-A cleaned stool from the peri folds twice with a washcloth and then used that wash cloth to pat an area of denuded skin on the left upper buttocks approximately 3.5 to 4.0 centimeters (cm) x 2.5 cm with crusted area of yellow debris. The open area did not appear to be blanchable during the cares. NA-A applied AD ointment to the area. R20 stated she had a history of open areas and the cream had healed them. The resident stated that she should be checked and changed every two hours. - On 7/8/15, at 12:00 p.m. R20 remained in an upright position with the head of bed (HOB) at 35 to 45 degrees (upright). - On 7/8/15, at 2:50 p.m. R20 remained upright with HOB 35 to 45 degrees. - On 7/8/15, at 2:00 p.m. NA-A was asked if she reported the open area to the licensed practical nurse (LPN)-C assigned to R20. NA-A stated she was a trained medication aide (TMA) and could put the cream on the open area. NA-A verified she had not reported it to the licensed nurse, and that she was not qualified to do a skin assessment. On 7/7/15, at 8:14 a.m. R20 was interviewed and stated she had pulled a muscle in her neck, and so she was supposed to be on bedrest for six	F 157		

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F 157	Continued From page 3 weeks. When asked who told her to be on bed rest, she stated that was how long it would take to heal. R20 stated she would be getting out of bed that coming Friday, when the six weeks was over. R20 was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right ankle, abscess and cellulitis of the right leg and diabetes mellitus type II, had a history of pressure ulcers, and stroke with hemiparesis (inability to move half the body). The annual Care Area Assessment (CAA) dated 8/20/14, indicated R20 had a cognitive loss, had a recent decline in activities of daily living (ADL) and required assistance in all ADL. R20 refused care one to three times in the look back period and had a history of noncompliance with treatments. R20 was identified at risk for pressure ulcers related to limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify MD with changes. The care plan dated 8/26/14, indicated R20, had a history of pressure ulcers, had a pressure reduction mattress, and should be monitored for signs and symptoms of skin break down related to incontinence and immobility. R20 was to be assisted with repositioning, and staff should notify the doctor and the wound team to follow as needed. The care plan lacked new directions to check and change or reposition every two hours, related to residents wish to stay in bed for six weeks due to a self-diagnosed "pulled muscle" in her neck. A review of the Wound Clinic Notes as follows: - On 4/1/15 through 4/29/15, all documentation	F 157		

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F 157	Continued From page 4 refers to a right buttock wound; there was no documentation of a left buttock wound. - On 5/13/15, sheer wound of right shin deteriorated due to generalized decline of patient. "Optimize nutrition. Sheer wound of right buttock no change." - On 5/27/15, sheer wound of right shin deteriorated due to nutritional compromise. "Optimize nutrition. Sheer wound of right buttock no change." - On 6/10/15, sheer wound of right inferior shin improved. Sheer wound of right buttock (resolved on 6/10/15). - On 6/24/15, sheer wound of right inferior shin of at least 197 days duration, venous insufficiency improved (did not address right buttock). The Nursing Progress Notes were reviewed from 4/29/15, going forward: - On 4/29/15, un-timed indicated "wound rounds." R20 was seen on that date by the wound team who observed right shin and left buttock area wound and no new orders were written. However, the Wound Clinic notes dated 4/29/15, indicated a pressure ulcer on the right buttock. - On 5/25/15, untimed indicated a call placed to nurse practitioner (NP) to inform of complaint of pain in neck and shoulders and R20 had been using as needed Tylenol (a mild analgesic). R20 indicated to the nursing home staff that had not helped and R20 received a new order for Tramadol (a narcotic used to control pain). R20 continued to complain of neck pain on 6/22/15, 6/23/15, and remained in bed. - On 6/27/15, at 1:15 p.m. R20 received a bed bath, skin noted as intact. On 7/9/15, at 6:15 a.m. a nursing progress noted, "[R20] was approached to be repositioned with a pillow to promote skin integrity; she refused and	F 157		

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F 157	Continued From page 5	F 157		

said 'No honey.' After two hours R20 was re-approached and accepted to be repositioned to prevent further skin breakdown. will continue repositioning." The note was made after staff intervened. A review of the Physician Orders and medical record did not support the statement of bed rest. There was no documentation that a physician/provider was notified that R20 refused to get out of bed.

A review of the Wound Care Documentation book indicated:
- On 4/29/15, a wound progress note indicated R20 had wounds on right shin and left buttock area.
- On 6/14/15, bed bath, skin intact.
- On 6/20/15, did have wound on right lower extremity (RLE) and no other wounds were addressed.
- On 6/27/15, bed bath, skin intact.

The quarterly Minimum Data Set (MDS) dated 5/18/15, indicated R20 was cognitively intact, had no depression and did not reject cares. R20 required extensive assist of two staff for bed mobility, a total mechanical lift for transfers, toilet use, and extensive assist of one staff for locomotion on the unit. R20 was always incontinent and did not have a pressure ulcer.

The 24-hour Report sheet for 7/9/15, indicated prn Tramadol at 2:00 a.m., legs pain, and repositioned side by side once.

A review of the 24-hour Nursing Report book indicated: on 7/9/15, at 1:30 p.m. there was no new documentation in the wound care book, the nursing progress notes, or 24 hour report form to indicate the new left buttock wound. There was

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F 157	Continued From page 6 no mention of the open area observed during cares on 7/8/15. However after surveyor intervention, the facility did notify the NP on 7/9/15, (untimed) as the Nursing Progress Note indicated an observed open area on the left buttock, area measures approximately 4 cm x 2 cm, no drainage or swelling, and denied pain. "Area surrounding the open area is dark in color, does blanch. Dark area measures approximately 10 cm x 5 cm. Called placed to 3 contacts to inform of open area, unable to connect with any. call placed to NP [nurse practitioner], message left informing of open area. Also placed in wound book. Area cleansed and left open at this time, awaiting call back from NP. Have discussed the need for [R20] to position to relieve pressure-avoid this open area getting bigger. R20 stated that she does move herself around and that should be enough. Res [resident] has refused getting weighed in the morning with sling and lift. [R20] does not get out of bed per her decision. Benefits of changing position and getting up were discussed." Imbedded in the progress note was a new order from the NP which ok'd the Standing Orders to apply barrier cream to open area on coccyx every shift with cares. On 7/9/15, at 1:37 p.m. LPN-B stated she was told about the open area in her nursing shift report, "let me go get my sheet." LPN-B returned less than one minute later and stated "I did not write anything down I guess. I talked to R20 today and I looked at her. I told her 'it is red, and I do think it's from pressure.' She refused to be repositioned, which she does frequently, and I told her it is a doctor's order to be weighed daily, but she refused." LPN-B stated she did view the buttocks. The rash was described to her as a very	F 157		

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F 157	Continued From page 7 red area with macular shapes, that crossed dermatomes, a discussion was had about what that might be. LPN-B stated she does get hot, "perhaps it was heat rash, I didn't notice it today, but then I didn't look." - At 2:16 p.m. the director of nursing (DON) stated "I will need to review the documentation/lack of documentation that you are seeing (MDS and wounds)." On 7/10/15, at 9:25 a.m. NA-A stated she did not document on the skin assessment sheet because it was not her official bath day. But she did tell the nurse. "That is not a new wound, it has looked much worse than that." The NA-A was not aware that it had been healed according to the wound book. The physician for R20 was unable for interview. A policy for notification of change was requested, but not provided.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure call light was within reach for 1 of 1 resident (R73) reviewed for	F 246		

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F 246	Continued From page 8 environmental concerns. Findings include: R73 was observed on 7/6/15, at 5:52 p.m. to be awake sitting up in bed with the call light cord located underneath head of the bed. The call light was not within R73's reach if he needed assistance from staff. Nursing assistant (NA)-E came in the room and when asked, stated call light cord should not be on floor, it should be within resident's reach. NA-E was observed to pull call light from underneath head of the bed and place it within reach of R73's right side. NA-E further stated resident was able to use call light and resident also confirmed he used the call light. The Admission Record, indicated R73 was admitted on 3/10/15, with diagnoses to include Diabetes type II, and symptoms of dizziness and giddiness. The admission Minimum Data Set (MDS) dated 3/16/15, noted R73 to have intact cognition. R73's Care Area Assessment (CAA) analysis of findings dated 3/18/15, indicated resident required assistance related to weakness, dizziness and unsteady gait, staff to assist as needed. CAA indicated resident was at risk for falls related to history of falls and weakness, staff to assist with transfers. The quarterly MDS dated 6/15/15, noted R73 to have fallen twice in the last 90 days and R73 also was noted not to have injured himself. R73's care plan dated 3/25/15, indicated R73's ability to perform activities of daily living (ADL's) independently was impaired, required assist with transfers, ambulated with assist and use of	F 246	**F246** • **Resident # 73 has had no adverse effects from not having his call light in reach. Call light device checked by maintenance so it can be clamped onto bed or area where resident can reach it.** • **Maintenance has done 100% room sweep to assure all call light devices are attachable and available for all residents.** • **ED/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Educate staff on call light policy and document if resident refused to have call light attached.** • **Findings of audit will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 246	Continued From page 9 walker. The care plan also indicated R73 was at risk for falls and the staff was to place the call light within reach. On 7/7/15, at 8:51 a.m. licensed practical nurse (LPN)-A stated he expected resident's call light to be put in bed with resident or around the bed table and if resident was in bed it should be with him. LPN-A further stated resident was independent and ambulated with rolling walker. On 7/10/15, at 8:26 a.m. director of nursing (DON) was interviewed regarding call light placement. DON stated she expected staff should follow facility policy with placement of call light. The resident call system policy dated 4/1/08, indicated "all residents have call system access while in bed or while sitting at their bedside or in the bathroom."	F 246		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	**F274** • **Resident # 5 has had a new comprehensive assessment completed related to her decline in transfers and mobility and significant change MDS has been completed.** • **All residents at St. Olaf Residence (SOR) who have a**	

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F 274	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a significant change in status for 1 of 1 resident (R5) who had a decline in transfer ability, bed mobility, and ambulation. Findings include: On 7/8/15, at 7:50 a.m. R5 was observed for morning cares. R5 was lying down in bed, nursing assistant (NA)-G washed hand, gloved, washed R5's upper body. Bruises were noted on both upper arms and on her right upper thigh. NA-G then washed hands, re applied another pair of gloves and with new washcloth cleaned lower body and peri area. NA-G washed hands, applied gloves again, applied cream to peri area, washed hands, applied gloves then applied powder under R5's breasts, put on a shirt with no bra and with assist of NA-D and much encouragement sat R5 up to side of bed. R5 was continually stating "just get me in the chair; just get me in the chair." R5 was yelling out during all morning cares. With the EZ stand (mechanical standing lift) positioned in front of resident and feet on stand, R5 put her hand on the hand holders, NA-D secured the straps around wrist/hands and back, R5 appeared very upset and repeating "I'm scared, I'm scared." NA-G and NA-D continued to attempt to calm R5; raised R5 with EZ stand to wipe after R5 had a bowel movement. R5 continued to yell "I don't like the stand" and arms at that time started to slip out of EZ stand with her body slowly lowering. NA-G was able to get a clean incontinent product on, pulled up her pants and transferred R5 to bariatric wheelchair at which	F 274	**significant change in mobility or ambulation may be affected by this practice.** • **Nursing staff will be educated on alerting the DON on any changes in a patient's mobility so a new comprehensive assessment can be completed if indicated.** • **DON/Designee to check 24 hour board and review for any changes in resident transfers and mobility changes.** • **DON/ Designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audit will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 274	Continued From page 11 time R5 immediately calmed down. The NA's purposefully swung R5's legs over the side of the bed to transfer and position for the EZ stand use. On the morning of the 7/8/15, at 7:50 a.m., 7/9/15, at 7:09 a.m., and 7/10/15, in the morning as she wheeled herself onto the elevator, R5 was observed to be seated in the wheelchair (w/c) and was not observed to self transfer nor did she ambulate at anytime. On 7/9/15, at 11:40 a.m. R5 was transferred into the bed with staff assist utilizing a Hoyer lift. R5's diagnoses included paranoid schizophrenia, bipolar disorder, incontinence, lumbago (low back pain) and obesity as listed on the undated Resident Admission Record. The Care Area Assessment (CAA) dated 1/6/15, indicated R5 used a wheelchair, had physical limitations, and was at risk for falls due to unsteady gait, transferred independently and for staff to assist as needed. R5's current care plan dated 1/9/15, indicated R5 was independent with bed mobility, transferring, w/c (wheelchair) locomotion, ambulated very short distance (a few steps) with unsteady gait and required occasional assist with wheelchair locomotion. The care plan information for ambulation, transfers and bed mobility contraindicated the observations on 7/8 and 7/9/15. The quarterly Minimum Data Set (MDS) dated 4/7/15, indicated R5 had moderate cognitive impairment, was independent with bed mobility, transfers, and walking.	F 274		

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F 274	Continued From page 12 During an interview on 7/8/15, at 8:08 a.m. NA-G stated the Hoyer (mechanical lift) tipped over one time. R5 was over the bed at the time, so she was lowered down and that was why they do not use it. NA-G stated it took two or more staff to help R5, she will fight them, will not let them roll her to the front so they could wash her back and bottom when she was in the bed, so they use the EZ stand. NA-G verified R5 was slipping out of the EZ stand, stating "we report it, they are aware of it, maybe they need to get a different EZ stand, I don't know." NA-G then showed surveyor the nursing assistant treatment sheet which indicated R5 was assist of two for transfers and assist of one for wheelchair. During an interview on 7/9/15, at 11:23 a.m. NA-H stated they have used the EZ stand for the past two to three weeks and that R5 was complaining, "we told the nurses." During an interview on 7/9/15, at 12:41 p.m. director of nursing (DON) stated she was not sure when there was a change in R5's transferring ability. The administrator stated "we have talked about doing a significant change." During an interview on 7/9/15, at 12:49 p.m. the MDS coordinator stated "I do not know when it was identified, therapy told him they were picking her up due to a decline last week, I'm not here all of the time, that morning it was discussed to put her on for a significant change." During an interview on 7/10/15, at 8:56 a.m. licensed practical nurse (LPN)-A stated that the nursing assistant care sheet for 7/6/15 and 7/7/15, indicated to use the EZ stand with assist	F 274		

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	245387	A. BUILDING _____ B. WING _____	07/10/2015

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F 274	Continued From page 13 of two staff. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care."	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	**F278** • **Corrections on assessments on resident # 20, and 19 have been completed.** • **Other residents at risk for inaccurate assessments have been reviewed and updated as needed.** • **DON/ Designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audit will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 278	Continued From page 14 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for 2 of 3 residents (R19, R20) reviewed for dental concerns, pressure and venous stasis ulcers. Findings include: R19 was observed on 7/7/15, at 8:53 a.m. and was noted to have several missing teeth to the front, back and sides of both her upper and lower jaws. On 7/8/15, at 7:22 a.m. R19 was asked if she had any problems with chewing or eating R19 stated "no." R19 stated she had been to the dentist and had been told was getting her partials soon but was not sure how soon. R19 indicated she was able to brush her own teeth after set and she had completed it this morning when she had gotten up. On 7/8/15, at 11:55 to 12:15 p.m. during continuous meal observation R19 was approached and asked how the food was she stated "never good am a southern girl and lived in the farm and we had good food." When asked if she was having any problems with chewing the food due to the several missing teeth R19 stated	F 278		

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F 278	Continued From page 15 "no." During observation R19 was noted to bite her sandwich with her gums and one tooth on the lower front jaw and chewed it no difficultly or discomfort noted. R19 was admitted to the facility on 7/8/04, with diagnoses including hemiplegia, mild cognitive impaired, peripheral vascular disease (PVD) and presbyopia obtained from annual MDS dated 5/25/15. R19's quarterly MDS dated 2/24/15, identified R19 required extensive physical assist of one staff with personal hygiene, had no behaviors which included rejection of cares and had moderately impaired cognition. The Oral/Dental Status was left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. Review of documents revealed the following: -Doorstep Healthcare Services progress note dated 3/18/15, indicated R19 had an initial exam. -Doorstep Healthcare Services progress note dated 4/15/15, indicated care completed "Preliminary impressions for (teeth #18, #21, #27, #29 are present) full upper and partial lower resin base dentures are taken with genie material..." -Nutritional Assessment dated 5/27/15, indicated R19 did not have chewing or swallowing problems however the assessment did not indicated R19 had missing teeth or dentures/partials. The most recent annual MDS dated 5/25/15, The	F 278		

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F 278	Continued From page 16 Oral/Dental Status was left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing and was marked as "None of the above were present." R19's activities of faily living (ADL) functional CAA dated 6/1/15, indicated R19 required assistance of one with cares; had hemiplegia related to cerebrovascular accident (CVA). In addition, the dental section Care Area Assessment (CAA) did not trigger. R19's ADL care plan dated 6/3/14, indicated R19 required assistance with all ADLs which included dressing, bathing, grooming and hygiene. The care plan directed staff to assist with all cares and encourage participation and to monitor for decline. R19's nutritional status care plan dated 9/15, indicated R19 had an alteration in nutrition related to the need for a therapeutic diet. Neither R19's CAA nor care plans addressed R19's dental/oral health status and cares. On 7/8/15, at 10:19 a.m. consultant dietician (CD) stated usually in the annual assessment she would usually not indicated the dental/oral status for residents in the nutritional assessment and did it only for the initial assessment. When asked how she got her information which included a resident dental status CD stated usually she would go off the nursing assessments and most of the time the nursing assessments were not timely and if they were not correctly done then she would also have the wrong data. CD stated she would usually check with the residents if they	F 278		

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F 278	Continued From page 17	F 278		

had any chewing or swallowing problems and for R19 she had indicated the missing teeth did not cause any problems. CD acknowledged she should have still indicated on the side of R19's nutritional assessment that "she was missing teeth or was denture less."
- At 2:27 p.m. the consultant MDS coordinator verified no dental comprehensive assessment had been completed despite R19's dental concerns. In addition he verified the comprehensive MDS was inaccurate and stated the comprehensive annual MDS should have captured the missing teeth and all the dental status concerns.
- At 2:36 p.m. after the consultant MDS coordinator reviewed the entire care plan he verified a care plan had not been developed to identify R19's dental concerns. MDS coordinator indicated although an ADL care plan had been developed it had not address the dental concerns R19 had and care.

On 7/9/15, at 10:15 a.m. when asked what cares R19 required nursing assistant (NA)-B stated night shift got her up and was not sure after looking through the 1st Floor Team 1 Assignment NA-B stated R19 required assistance of one with ADLs which included dental care and because R19 was gotten up by the night shift the staff assisted her with dental cares also.
- At 3:17 p.m. the director of nursing (DON) approached and stated the facility did not have an assessment policy and rather followed the Resident Assessment Instrument (RAI) manual for assessments.

On 7/10/15, at 9:46 a.m. when asked what her expectation was of the MDS nurse when completing MDSs DON stated she expected the

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F 278	Continued From page 18 MDS nurse to follow State and Federal regulations. When asked if the MDS nurse was supposed to complete a comprehensive assessment for R19's dental stated DON again stated they are supposed to follow State and Federal regulations. R20 presented with a new pressure ulcer risk after had a self-imposed 44 day bed rest. R20 was obese and had a pressure reduction mattress, but not a pressure relief mattress on the bed. The facility failed to identify and assess the wound. R20 was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right ankle, abscess and cellulitis of the right leg and diabetes mellitus type II, had a history of pressure ulcers, and stroke with hemiparesis (inability to move half the body). The annual CAA dated 8/20/14, indicated R20 had a cognitive loss, had a recent decline in ADL and required assistance in all ADL. R20 refused care one to three times in the look back period and had a history noncompliance with treatments. R20 was at risk for pressure ulcers related to limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify medical doctor (MD) with changes. The care plan dated 8/26/14, indicated R20, had a history of pressure ulcers, had a pressure reduction mattress, and should be monitored for signs and symptoms of skin break down related to incontinence and immobility. R20 was to be assisted with repositioning, and staff should notify	F 278		

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F 278	Continued From page 19 the doctor and the wound team to follow as needed. A review of the wound clinic notes as follows: - On 4/1/15 through 4/29/15, (time limited by last revisit date), all documentation refers to a right buttock wound, there was no documentation of a left buttock wound. - On 5/13/15, sheer wound of right shin deteriorated due to generalized decline of patient: Optimize nutrition. Sheer wound of right buttock no change. The Nursing Progress Notes were reviewed from 4/29/15, going forward: - On 4/29/15, untimed nursing progress notes indicated "wound rounds." R20 was seen on that date by the wound team who observed right shin and left buttock area wound and no new orders were written. However, the Wound Clinic notes dated 4/29/15, indicated a pressure ulcer on the right buttock. A review of the wound care documentation book indicated: - On 4/29/15, a wound progress note indicated R20 had wounds on right shin and left buttock area. The quarterly MDS dated 5/18/15, indicated R20 was cognitively intact, had no depression and did not reject cares. R20 required extensive assist of two staff for bed mobility, a total mechanical lift for transfers, toilet use, and extensive assist of one staff for locomotion on the unit. R20 was always incontinent and did not have a pressure ulcer. The quarterly MDS lacked evidence of the right wound ulcer being identified on the MDS.	F 278		

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F 278	Continued From page 20 On 7/9/15, at 1:37 p.m. licesned practcial nurse (LPN)-B stated she was told about the open area in her nursing shift report, "let me go get my sheet." LPN-B returned less than one minute later and stated "I did not write anything down I guess. I talked to R20 today and I looked at her, I told her 'it is red, and I do think it's from pressure', she refused to be repositioned, which she does frequently, and I told her it is a doctors order to be weighed daily, but she refused." LPN-B stated she did view the buttocks. The rash was described to her as a very red area with macular shapes, that crossed dermatomes, a discussion was had about what that might be. LPN-B stated she does get hot, "perhaps it was heat rash, I didn't notice it today, but then I didn't look." On 7/9/15, at 2:16 p.m. the DON stated "I will need to review the documentation/lack of documentation that you are seeing (MDS and wounds)." On 7/10/15, at 9:25 a.m. NA-A stated she did not document on the skin assessment sheet because it was not her official bath day, but she did tell the nurse. "That is not a new wound, it has looked much worse than that." The NA-A was not aware that it had been healed according to the wound book. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, the "DEFINITION PRESSURE ULCER" was "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." In addition, the manual provided "Steps for	F 278		

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F 278	Continued From page 21 Assessment" and directed the staff to: "1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer risk assessments. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. 3. Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing)."	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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F 280	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care to reflect the need for assistance with toileting for 1 of 3 residents (R31) reviewed for accidents, who had repeated falls. Findings include: On 7/10/15, at 10:20 a.m. R31 was observed walking in hallway with nursing assistant (NA)-F. R31 had his left arm in a sling and pulled up to nipple line. R31's right hand held the walker (which was a one sided stand walker with 4-pronged walker). The left foot was extended in front of him and did not appear to bend at the knee. While R31 ambulated, he was hunched forward with his left leg extended in front of him, and he did a hop/shuffle step to catch up to the walker. R31 was admitted to the facility on 9/19/12, with admission diagnoses of vascular dementia, dysphagia (difficulty swallowing), muscle spasm, osteoarthritis, persistent mental disorder, depression, left hemiplegia, and neurogenic bladder. The Care Area Assessment (CAA) dated 9/12/14, indicated R31 was cognitively intact. R31 required limited assistance with walking, hygiene, bathing and dressing. CAA directed staff to assist as needed, monitor for changes in status and notify MD of changes. In addition the CAA indicated	F 280	**F280** • **Resident # 31 has had his care plan reviewed and revised for falls and toileting care.** • **Other residents with recent falls have had their care plan reviewed and revised if indicated.** • **DON/designee will review and revise residents fall and toileting care plan.** • **Nursing staff will be educated to alert the DON to any changes in a resident's toileting needs and falls so care plan can be revised to reflect the needs of the resident.** • **DON/ Designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audit will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 280	Continued From page 23 R31 had moderate depression which had increased. Falls CAA indicated R31 was at risk for falls related to hemiparesis, independent transfers, had a fall that quarter when transferring to toilet and physical therapy (PT) and occupational therapy (OT) had been ordered. The Care Plan dated 9/16/14, indicated R31 had intact cognition, required assistance related to left sided weakness, hemiparesis, limited mobility and that the resident prefers to be as independent as possible. R31 received range of motion (ROM) and a walking program with restorative nursing. R31 used a quad can with assistance. R31 used a large bathroom (communal) for toileting for easier transfers. Staff was to offer toileting assistance as needed as R31 was currently continent of bowel and bladder and able to toilet independently. R31 "refuses assist and prefers to be independent." The care plan lacked direction for increased assistance in transfers related to recent decline in abilities. The Minimum Data Set (MDS) dated 3/13/15, indicated R31 had intact cognition did not have behaviors and required limited assist of one staff with bed mobility, transfers, and toilet use. The plan of care for R31 was not revised for the needed assist of one staff bed mobility, transfers, and toilet use. On 7/10/15, at 12:00 noon the director of nursing was interviewed and verified the care plan was not updated to review the need for increased assistance with toileting.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 24 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care as directed for 1 of 1 resident (R25) reviewed for activities of daily living (ADLs) and for 1 of 1 resident (R73) whose call light was not within reach. Findings include: On 7/6/15, at 5:16 p.m. R25 was observed un-removed multiple white facial hairs approximately half (1/2) inch on her chin area. On 7/7/15, at 12:15 p.m. during a random observation R25 was observed seated on her wheelchair in the dining table still noted to have the white facial hairs in her chin. On 7/8/15, at 7:31 a.m. to 8:06 a.m. when morning cares were observed nursing assistant (NA)-B dressed R25, provided pericare's and oral cares. During the entire observation NA-B never offered to remove the visible white facial hairs. On 7/8/15, at 11:43 a.m. R25 was observed lying in bed awake looking around the room facial hairs remained on the chin. On 7/9/15, at 7:59 a.m. R25 was seated on her wheelchair in the dining table when still had multiple white facial hairs in her chin. When	F 282	**F282** • **Resident #25 has received proper grooming from staff including removing facial hairs from chin.** • **Any resident with facial hair and that requires assistance with grooming could be affected by this practice.** • **Educate staff on morning cares policy including proper bathing and grooming.** • **ED/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Resident #25 has had no adverse effects from not having her call light in reach. Call light device checked by maintenance so it can be clamped onto bed or area where resident can reach it.**	

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	245387	A. BUILDING _____ B. WING _____	07/10/2015

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F 282	Continued From page 25 approached and asked if the facial hairs bothered her she smiled and was not able to respond. On 7/9/15, at 10:56 a.m. both the licensed practical nurse (LPN)-B and NA-B verified the facial hairs. When asked if she had noticed the hairs NA-B stated she had and did take it out because she herself had facial hair and did not think it bothered R25 as she pointed to her upper lip. NA-B further stated male residents had razors but R25 did not have one. -At 10:58 a.m. when asked what her expectation was LPN-B stated she expected NA-B to have removed the facial hairs "If it's on the care plan as some residents are independent." When surveyor clarified if R25 was independent then LPN-B stated "She is a white female and it is not normal to have facial hair" LPN-B further stated she had not been close to R25 during her shift. On 7/10/15, at 8:32 a.m. R25 was observed seated on her wheelchair in the dining room still had facial hairs in her chin. R25's ADL functional status/rehabilitation Care Area Assessment (CAA) dated 3/7/15, indicated R25 required some assistance with cares related to weakness. R25's ADL functional/rehabilitation potential care plan dated 3/10/15, indicated R25's ability to care for self was impaired related to weakness with goal to "will be neat, clean ..." The care plan directed staff to set up supplies for grooming and assist of one daily to complete tasks. In addition behavioral symptom care plan dated 3/10/15, indicated R25 did not have any mood/behavior issues.	F 282	• **Maintenance has done 100% room sweep to assure all call light devices are attachable and available for all residents.** • **ED/ designees will make rounds 3x weekly to monitor that residents call lights are in place. Corrective action to staff will take place at time of infraction.** • **Educate staff on call light policy and document if resident refused to have call light attached.** • **Findings of audit will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 282	Continued From page 26 Review of R25's Body Audit Form completed during the following dates 4/7/15, 4/14/15, 5/5/15, 5/12/15, 5/18/15 and 6/30/15, it was revealed either a bed bath or shower had been given to R25 and the box "Shaved (Men & Women)" had never been checked off for any of the dates. R25's diagnoses included Alzheimer's disease, and osteoporosis obtained from the quarterly Minimum Data Set (MDS) dated 6/1/15. In addition the MDS indicated R25 required extensive physical assist of one staff with toileting, dressing and personal hygiene which included shaving and washing/drying face and hands. On 7/9/15, at 9:45 a.m. the director of nursing (DON) stated staff was supposed to follow the facility policy and directed surveyor she had provided the policy. DON also stated a resident had right for choices and had the right to refuse. When asked if R25 was being to make care decision as she had dementia DON stated she would have to see how far her dementia was progressed. Morning Care policy dated April 1, 2008, directed staff to "9. Shaving as needed; assist as needed..." R73's call light was not within reach according to the plan of care. R73 was observed on 7/6/15, at 5:52 p.m. to be awake sitting up in bed with the call light cord located underneath head of the bed. The call light was not within R73's reach if he needed assistance from staff. NA-E came in the room	F 282		

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F 282	Continued From page 27 and when asked, stated call light cord should not be on floor, it should be within resident's reach. NA-E was observed to pull call light from underneath head of the bed and place it within reach of R73's right side. NA-E further stated resident was able to use call light and resident also confirmed he used the call light. R73's care plan dated 3/25/15, indicated R73's ability to perform ADLs independently was impaired, required assist with transfers, ambulated with assist and use of walker. The care plan also indicated R73 was at risk for falls and the staff was to place the call light within reach. On 7/7/15, at 8:51 a.m. LPN-A stated he expected resident's call light to be put in bed with resident or around the bed table and if resident was in bed it should be with him. LPN-A further stated resident was independent and ambulated with rolling walker. On 7/10/15, at 8:26 a.m. DON was interviewed regarding call light placement. DON stated she expected staff should follow facility policy with placement of call light. The resident call system policy dated 4/1/08, indicated "all residents have call system access while in bed or while sitting at their bedside or in the bathroom."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,	F 309		

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F 309	Continued From page 28 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 identify and investigate the causative factors for bruises for 1 of 3 residents (R5) and the facility failed to ensure a physician order for physical and occupational therapy (PT/OT) was carried forward for 1 of 3 residents (R5). Findings include: Bruises: Review of nurse's notes from 3/7/15, indicated skin was clean, dry and intact; on 3/26/15, skin was intact; on 5/4/15, after a fall, no physical injuries noted after total body audit; on 6/13/15, fall follow-up, a left outer thigh bruise was noted. No other injuries were observed when the nurse did a body check; 7/5/15 follow-up from 7/4/15, fall: a bruise 13 centimeters (cm) by 15 cm was noted on outer lateral view of right hip. There was no documentation of upper arm bruises until 7/8/15, after surveyor noted them and reported to the director of nursing (DON). During an interview on 7/8/15, at 8:08 a.m. nursing assistant (NA)-G stated the Hoyer (mechanical lift) tipped over one time. R5 was over the bed at the time, so she was lowered down and that was why they do not use it. NA-G stated she was told the bruises on her arms and legs were from when R5 recently fell. NA-G	F 309	**F309** • **Resident #5 has been seen by therapy for screening.** • **DON has reviewed causative factors for bruises and investigated incident that occurred to cause bruises on Resident #5** • **DON/designee will review and investigate any bruises of unknown origins and review causative factors for all residents.** • **Any resident with new therapy orders will have a copy of Dr.'s order placed in therapy and DON mailbox to improve communication between departments in place of leaving a voice message.** • **Educate staff on system change.** • **DON/ Designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.**	

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F 309	Continued From page 29 stated it takes two or more staff to help R5, she will fight them, will not let them roll her to the front so they could wash her back and bottom when she was in the bed, so they use the EZ stand (mechanical stand lift). NA-G verified R5 was slipping out of the EZ stand, stating "we report it, they are aware of it, maybe they need to get a different EZ stand, I don't know." NA-G then showed surveyor the nursing assistant treatment sheet which indicated R5 was assist of two for transfers and assist of one for wheelchair. During an interview on 7/8/15, at 9:42 a.m. licensed practical nurse (LPN)-A stated R5 will fight cares, yell during any that she did let staff complete. LPN-A stated a body audit should be completed on bath days, on 7/4/15, R5 refused her bath thus a body audit was not done. LPN-A stated the bruises on the arms are or "could be" from the ill-fitting wheelchair she had, R5 used to sink down in the wheelchair, her arms would catch on the back and sides of the wheelchair and that is why we got a new larger one. LPN-A states he has observed her in the EZ stand and if the belt is put on correctly and she cooperates by holding on properly, it works well. During an interview on 7/8/15, at 12:00 p.m. the DON stated R5 was getting breakdown on sides of body so she was sized to a larger chair on 7/3/15. R5 was upset about it, stated "therapy took my chair" and slid herself out of the chair onto the floor. DON stated R5 has no core strength, staff helped lower her to the floor, then used a Hoyer to put her back in bed and that the bruises could be when we were rolling her back and forth to get the Hoyer sling under her. DON stated "I would expect documentation on any bruising in the chart. I did check her over after we	F 309	• **Any bruise noted on residents will have causative factors reviewed and IR completed for thorough investigation.** • **Staff educated on reporting new bruises to DON so investigation can start ASAP.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 309	Continued From page 30 got her in the bed and there were no bruises. I find they document in many different places, I will check." During an interview on 7/9/15, at 8:21 a.m. DON stated after she assessed R5's bruises, she submitted a vulnerable adult report and has started an investigation for bruises of unknown origin. DON further stated R5 was assessed by PT yesterday and deemed not safe to use the EZ stand so staff now uses the Hoyer. During an interview on 7/10/15, at 8:56 a.m. LPN-A stated the nursing assistant care sheet for 7/6/15 and 7/7/15, indicated to use the EZ stand with assist of two staff. PT/OT: Based on observation, interview and document review the facility failed to ensure a mechanical device was utilized in a safe manner for 1 of 1 resident (R5) reviewed for accidents. In addition, the facility failed to ensure grab bars in toilet were in good operating condition and wheelchair armrests was maintained in a safe operating manner for 1 of 1 resident (R24). Findings include: On 7/8/15, at 7:50 a.m. R5 was observed for morning cares. R5 was lying down in bed; NA-G washed hand, gloved, and washed R5's upper body. Bruises were noted on both upper arms and on her right upper thigh. R5 was continually stating "just get me in the chair; just get me in the chair." R5 was yelling out during all morning cares. With the EZ stand positioned in front of resident and feet on stand, R5 put her hand on	F 309		

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F 309	Continued From page 31 the hand holders, NA-D secured the straps around wrist/hands and back, R5 appeared very upset, repeating "I'm scared, I'm scared." NA-G and NA-D continued to attempt to calm R5. R5 continued to yell "I don't like the stand" and arms at that time started to slip out of EZ stand with her body slowly lowering. R5 appeared distressed calling out "I'm going to fall." NA-G was able to get a clean incontinent product on, pulled up her pants and transferred R5 to bariatric wheelchair (W/C) at which time R5 immediately calmed down. On 7/9/15, at 7:09 a.m. R5 was dressed, sitting in a wheelchair, wanted to go outside to the patio. Staff stated R5 was up at 6:00 a.m. at which time morning cares were completed. - At 9:08 a.m. two aides and one nurse attempted to toilet R5. R5 was screaming and yelling and refusing cares. R5's diagnoses included paranoid schizophrenia, bipolar disorder, incontinence, lumbago (low back pain) and obesity as listed on the undated Resident Admission Record. The Care Area Assessment (CAA) dated 1/6/15, indicated R5 used a wheelchair, had physical limitations, and was at risk for falls due to unsteady gait, transferred independently and for staff to assist as needed. R5's care plan dated 1/9/15, indicated R5 was independent with bed mobility, transferring, w/c locomotion, walks very short distance (a few steps) with unsteady gait and requires occasional assist with wheelchair locomotion. The quarterly Minimum Data Set (MDS) dated	F 309		

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F 309	Continued From page 32 4/7/15, indicated R5 had moderate cognitive impairment, was independent with bed mobility, transfers, and walking. Review of physician progress notes dated 6/4/15, indicated R5 was very limited in her ambulation, gets around in a W/C due to chronic degenerative joint disorder (DJD) of the knees and knee pain. Review of a Physician's Telephone Orders dated 6/12/15, indicated "OK for PT/OT to evaluate and treat." On 6/15/15, another order for "PT to eval [evaluate] and tx [treat] for WC safety, OK for lip mattress." The medical record lacked evidence the Physician Orders had been communicated to therapy. During an interview on 7/8/15, at 8:01 a.m., LPN-A stated the EZ stand was the only way they can get R5 up which she generally refuses but hollers more with the Hoyer lift (mechanical lift). LPN-A further stated they tried the Hoyer a while ago and it did not work. During an interview on 7/8/15, at 8:08 a.m., NA-G stated the Hoyer tipped over one time. R5 was over the bed at the time, so she was lowered down and that was why they do not use it. NA-G stated it takes two or more staff to help R5, she will fight them, will not let them roll her to the front so they could wash her back and bottom when she was in the bed, so they use the EZ stand. NA-G verified R5 was slipping out of the EZ stand, stating "We report it, they are aware of it, maybe they need to get a different EZ stand, I don't know." NA-G then showed surveyor the nursing assistant treatment sheet which indicated R5 was assist of two for transfers and assist of one for wheelchair.	F 309		

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F 309	Continued From page 33 During an interview on 7/8/15, at 9:42 a.m. LPN-A stated R5 will fight cares and would yell during any that she did let staff complete. LPN-A stated he has observed her in the EZ stand and " if the belt is put on correctly and she cooperates by holding on properly, it works well. " During an interview on 7/8/15, at 10:33 a.m. LPN-A stated the Hoyer was never used to transfer R5, just to get her up off the floor when she fell. LPN-A further stated to his knowledge the Hoyer never tipped over when staff was using it, they have always used the EZ stand "R5 can transfer herself from wheelchair to bed and does do this." During an interview on 7/9/15, at 8:07 a.m. LPN-A stated R5 was now a Hoyer lift due to therapy changing it yesterday. LPN-A stated there are no assessments for use of the Hoyer, but residents are assessed by therapy for use of the EZ stand. The assessment for the EZ stand was requested. LPN-A stated "it was before my time, I will look for it." - At 8:13 a.m. LPN-A stated he could not find it and was requesting medical records to look for it. - At 9:31 a.m. the physical therapy director (PTD) stated there was no assessment to use the EZ stand and that nursing or therapy can change to use of the Hoyer if transfers are unsafe, but that therapy needed orders for the EZ stand assessment. PTD stated "I didn't know about the use of the EZ stand, we never recommended it." - At 11:23 a.m. NA-H stated they have used the EZ stand for the past two to three weeks and that R5 was complaining, "We told the nurses." - At 12:41 p.m. DON stated she was not sure when there was a change in R5's transferring	F 309		

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F 309	Continued From page 34 ability. The administrator stated "we have talked about doing a significant change." During an interview on 7/10/15, at 8:56 a.m. LPN-A states that the nursing assistant care sheet for 7/6/15 and 7/7/15 indicated to use the EZ stand with assist of two staff. Review of the facility policy, Lift - Sit to Stand dated 4/1/08 directed that staff must be trained in lift use and safety precautions and transfer according to manufacture direction guidelines. The policy lacked direction for assessment of resident prior to use. Review of the facility policy, Rehabilitation Services Orders dated 4/1/08, indicated the facility provided physical, occupational, or speech therapy to attain or maintain function and/or prevent decline with a physician-ordered treatment plan and that the therapy department should be notified of any physician orders and rehabilitation should be noted on the resident's care plan.	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 did not ensure removal of facial	F 312	**F312** • **Resident #25 has received proper grooming from staff including removing facial hairs from chin.** • **Any resident with facial hair and that requires assistance with grooming could be affected by this practice.**	

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F 312	Continued From page 35 hair was provided for 1 of 1 resident (R25) who are unable to carry out grooming services reviewed for activities of daily living (ADLs) Findings include: On 7/6/15, at 5:16 p.m. R25 was observed un-removed multiple white facial hairs approximately half (1/2) inch on her chin area. On 7/7/15, at 12:15 p.m. during a random observation R25 was observed seated on her wheelchair in the dining table still noted to have the white facial hairs in her chin. On 7/8/15, at 7:31 a.m. to 8:06 a.m. when morning cares were observed nursing assistant (NA)-B dressed R25, provided pericare's and oral cares. During the entire observation NA-B never offered to remove the visible white facial hairs. On 7/8/15, at 11:43 a.m. R25 was observed lying in bed awake looking around the room facial hairs remained on the chin. On 7/9/15, at 7:59 a.m. R25 was seated on her wheelchair in the dining table when still had multiple white facial hairs in her chin. When approached and asked if the facial hairs bothered her she smiled and was not able to respond. On 7/9/15, at 10:56 a.m. both the licensed practical nurse (LPN)-B and NA-B verified the facial hairs. When asked if she had noticed the hairs NA-B stated she had and did take it out because she herself had facial hair and did not think it bothered R25 as she pointed to her upper lip. NA-B further stated male residents had razors but R25 did not have one.	F 312	• **Other residents who require assistance with removal of facial hairs are receiving this assistance if indicated.** • **Educate staff on morning cares policy including proper bathing and grooming.** • **ED/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 312	Continued From page 36 -At 10:58 a.m. when asked what her expectation was LPN-B stated she expected NA-B to have removed the facial hairs "If it's on the care plan as some residents are independent." When surveyor clarified if R25 was independent then LPN-B stated "She is a white female and it is not normal to have facial hair" LPN-B further stated she had not been close to R25 during her shift. On 7/10/15, at 8:32 a.m. R25 was observed seated on her wheelchair in the dining room still had facial hairs in her chin. R25's ADL functional status/rehabilitation Care Area Assessment (CAA) dated 3/7/15, indicated R25 required some assistance with cares related to weakness. R25's ADL functional/rehabilitation potential care plan dated 3/10/15, indicated R25's ability to care for self was impaired related to weakness with goal to "will be neat, clean ..." The care plan directed staff to set up supplies for grooming and assist of one daily to complete tasks. In addition behavioral symptom care plan dated 3/10/15, indicated R25 did not have any mood/behavior issues. Review of R25's Body Audit Form completed during the following dates 4/7/15, 4/14/15, 5/5/15, 5/12/15, 5/18/15 and 6/30/15, it was revealed either a bed bath or shower had been given to R25 and the box "Shaved (Men & Women)" had never been checked off for any of the dates. R25's diagnoses included Alzheimer's disease, and osteoporosis obtained from the quarterly Minimum Data Set (MDS) dated 6/1/15. In addition the MDS indicated R25 required	F 312		

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F 312	Continued From page 37 extensive physical assist of one staff with toileting, dressing and personal hygiene which included shaving and washing/drying face and hands. On 7/9/15, at 9:45 a.m. the director of nursing (DON) stated staff was supposed to follow the facility policy and directed surveyor she had provided the policy. DON also stated a resident had right for choices and had the right to refuse. When asked if R25 was being to make care decision as she had dementia DON stated she would have to see how far her dementia was progressed. When asked what her expectation was of staff filling the Body Audit Form as it had been noted left blank in the "shaving" boxes DON stated the staff was supposed to follow the facility policy. Morning Care policy dated April 1, 2008, directed staff to "9. Shaving as needed; assist as 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. This REQUIREMENT is not met as evidenced by:	F 314		

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F 314	Continued From page 38 Based on observation, interview and document review, the facility failed to ensure interventions were in place to prevent development of a Stage 2 pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) for 1 of 2 residents (R20) reviewed for pressure ulcers. Findings include: The facility failed to notify the physician/provider of R20's self imposed 44 day bed rest, failed to identify and assess a new pressure ulcer risk, and failed to add interventions to the plan of care to reduce the risk of pressure ulcer development. R20 was obese and had a pressure reduction mattress, but not a pressure relief mattress on her bed. On 7/7/15, at 8:14 a.m. R20 was interviewed and stated she had pulled a muscle in her neck, and so she was supposed to be on bedrest for six weeks. When asked who told her to be on bedrest, she stated that was how long it would take to heal. R20 stated she would be getting out of bed that coming Friday, when the six weeks was over. On 7/8/15, at 9:57 a.m. nursing assistant (NA)-A was observed providing bathing cares to R20. R20 told NA-A to go easy as the terry cloth tears her skin. - On 7/8/15, at 10:17 a.m. R20 was rolled to the left, her back was red with creases from clothing/sheets, and appeared to have a macular rash that extended from the high thoracic area to low lumbar area, the macular rash was worse on left then on right. NA-A noticed the bed was wet in	F 314	**F314** • **Resident #20 has had skin assessment with care plan reviewed and revised for skin impairment.** • **Any resident with potential for skin impairment will have proper interventions placed on care plan to prevent development of pressure ulcers.** • **Staff will be educated on reporting any new open areas to DON so proper assessment and interventions can be implemented. Education of staff will also include basic skin care interventions for all residents.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 314	Continued From page 39 the peri area; and scrubbed the mattress. The NA-A continued with the bath. R20 had purple discoloration (in varying shades) from upper thighs (above gluteal fold) and included the buttocks. NA-A cleaned stool from the peri folds twice with a washcloth and then used that wash cloth to pat an area of denuded skin on the left upper buttocks approximately 3.5 to 4.0 centimeters (cm) x 2.5 cm with crusted area of yellow debris. The open area did not appear to be blanchable during the cares. NA-A applied AD ointment to the area. R20 stated she had a history of open areas and the cream had healed them. The resident stated that she should be checked and changed every two hours. - On 7/8/15, at 12:00 p.m. R20 remained in an upright position with the head of bed (HOB) at 35 to 45 degrees (upright). - On 7/8/15, at 2:50 p.m. R20 remained upright with HOB 35 to 45 degrees. R20 was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right ankle, abscess and cellulitis of the right leg and diabetes mellitus type II, had a history of pressure ulcers, and stroke with hemiparesis (inability to move half the body). The annual Care Area Assessment (CAA) dated 8/20/14, indicated R20 had a cognitive loss, had a recent decline in activities of daily living (ADL) and required assistance in all ADL. R20 refused care one to three times in the look back period and had a history noncompliance with treatments. R20 was at risk for pressure ulcers related to limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify MD with changes.	F 314		

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F 314	Continued From page 40	F 314		

The Care Plan dated 8/26/14, indicated R20, had a history of pressure ulcers, had a pressure reduction mattress, and should be monitored for signs and symptoms of skin break down related to incontinence and immobility. R20 was to be assisted with repositioning, and staff should notify the doctor and the wound team to follow as needed. The care plan lacked new directions to check and change or reposition every two hours, related to residents wish to stay in bed for six weeks due to a self-diagnosed "pulled muscle" in her neck.

A review of the Wound Clinic Notes as follows:
- On 4/1/15 through 4/29/15, (time limited by last revisit date), all documentation refers to a right buttock wound, there was no documentation of a left buttock wound.
- On 5/13/15, sheer wound of right shin deteriorated due to generalized decline of patient: Optimize nutrition. Sheer wound of right buttock no change.
- On 5/27/15, sheer wound of right shin deteriorated due to nutritional compromise. Optimize nutrition. Sheer wound of right buttock no change.
- On 6/10/15, sheer wound of right inferior shin improved. Sheer wound of right buttock (resolved on 6/10/15).
- On 6/24/15, sheer wound of right inferior shin of at least 197 days duration, venous insufficiency improved (does not address right buttock).

The Nursing Progress Notes were reviewed from 4/29/15, going forward:
- On 4/29/15, untimed nursing progress notes indicated "wound rounds." R20 was seen on that date by the wound team who observed right shin

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F 314	Continued From page 41 and left buttock area wound and no new orders were written. However, the Wound Clinic notes dated 4/29/15, indicated a pressure ulcer on the right buttock. - On 5/25/15, untimed nursing progress note indicated a call placed to nurse practitioner (NP) to inform of complaint of pain in neck and shoulders and R20 had been using as needed Tylenol (a mild analgesic). R20 indicated to the nursing home staff that had not helped and R20 received a new order for Tramadol (a narcotic used to control pain). R20 continued to complain of neck pain on 6/22/15, 6/23/15, and remained in bed. - On 6/27/15, at 1:15 p.m. R20 received a bed bath, skin noted as intact. - On 7/8/15, at 2:00 p.m. NA-A was asked if she reported the open area to the licensed practical nurse (LPN)-C assigned to R20. NA-A stated she was a trained medication aide (TMA) and could put the cream on the open area. NA-A verified she had not reported it to the licensed nurse, and that she was not qualified to do a skin assessment. - On 7/9/15, at 6:15 a.m. a nursing progress noted, "[R20] was approached to be repositioned with a pillow to promote skin integrity, she refused and said 'No honey.' After two hours R20 was re-approached and accepted to be repositioned to prevent further skin breakdown. will continue repositioning." The note was made after staff intervened. - On 7/9/15, an untimed note indicated: observed R20 had an open area on the left buttock, area measures approximately 4 cm x 2 cm, no drainage or swelling, and denied pain. "Area surrounding the open area is dark in color, does blanch. Dark area measures approximately 10 cm x 5 cm. Called placed to 3 contacts to inform	F 314		

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F 314	Continued From page 42 of open area, unable to connect with any. call placed to NP, message left informing of open area. Also placed in wound book. Area cleansed and left open at this time, awaiting call back from NP. Have discussed the need for R20 to position to relieve pressure-avoid this open area getting bigger. R20 stated that she does move herself around and that should be enough. Res [resident] has refused getting weighed in the morning with sling and lift. R20 does not get out of bed per her decision. Benefits of changing position and getting up were discussed." Imbedded in the progress note was a new order from the NP which ok'd the Standing Orders to apply barrier cream to open area on coccyx every shift with cares. The note was made after surveyor staff intervened. A review of the Physician Orders and medical record did not support the statement of bed rest. A review of the wound care documentation book indicated: - On 4/29/15, a wound progress note indicated R20 had wounds on right shin and left buttock area. - On 6/14/15, bed bath, skin intact. - On 6/20/15, did have wound on right lower extremity (RLE) and no other wounds were addressed. - On 6/27/15, bed bath, skin intact. The quarterly Minimum Data Set (MDS) dated 5/18/15, indicated R20 was cognitively intact, had no depression and did not reject cares. R20 required extensive assist of two staff for bed mobility, a total mechanical lift for transfers, toilet use, and extensive assist of one staff for locomotion on the unit. R20 was always incontinent and did not have a pressure ulcer.	F 314		

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F 314	Continued From page 43	F 314		

The 24-hour Report sheet for 7/9/15, indicated prn Tramadol at 2:00 a.m., legs pain, and repositioned side by side once.

A review of the 24-hour Nursing Report book indicated: on 7/9/15, at 1:30 p.m. there was no new documentation in the wound care book, the nursing progress notes, or 24 hour report form to indicate the new left buttock wound. (There was no mention of the open area observed during cares on 7/8/15).

On 7/9/15, at 1:37 p.m. LPN-B stated she was told about the open area in her nursing shift report, "let me go get my sheet." LPN-B returned less than one minute later and stated "I did not write anything down I guess. I talked to R20 today and I looked at her. I told her 'it is red, and I do think it's from pressure.' She refused to be repositioned, which she does frequently, and I told her it is a doctors order to be weighed daily, but she refused." LPN-B stated she did view the buttocks. The rash was described to her as a very red area with macular shapes, that crossed dermatomes, a discussion was had about what that might be. LPN-B stated she does get hot, "perhaps it was heat rash, I didn't notice it today, but then I didn't look."

On 7/9/15, at 2:16 p.m. the director of nursing (DON) stated "I will need to review the documentation/lack of documentation that you are seeing (MDS and wounds)."

On 7/10/15, at 9:25 a.m. NA-A stated she did not document on the skin assessment sheet because it was not her official bath day. But she did tell the nurse, "That is not a new wound, it has looked

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F 314	Continued From page 44 much worse than that." The NA-A was not aware that it had been healed according to the wound book. The Pressure Ulcers/Skin integrity/Wound Management policy dated 4/1/08, and last revised 9/13/11, indicated: A system is in place for the prevention, identification, treatment, and documentation of pressure and non-pressure wounds. ....Avoidable pressure ulcer means that the resident developed a pressure ulcer and that the facility did not do one or more of the following: -evaluate the resident's clinical condition and pressure ulcer risk factors; -define and implement interventions that are consistent with resident needs, resident goals and recognized standards of practice; -Monitor and evaluate the impact of the interventions; and or -Revise the interventions as appropriate.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to failed to ensure a mechanical device was utilized in a safe manner	F 323		

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F 323	Continued From page 45 for 1 of 1 resident (R5) reviewed for accidents. In addition, the facility failed to ensure grab bars in toilet were in good operating condition for 1 of 1 resident (R24)and wheelchair armrests was maintained in a safe operating manner for 2 of 2 residents (R24, R46). Findings include: Mechanical lift: On 7/8/15, at 7:50 a.m. R5 was observed for morning cares. R5 was laying down in bed, nursing assistant (NA)-G washed hand, gloved, washed R5's upper body. NA-D assisted R5 by swinging the legs over the bed edge and R5 needed much encouragement to sit up at the side of bed. R5 was continually stating "just get me in the chair, just get me in the chair." R5 was yelling out during all morning cares. With the EZ stand positioned in front of resident and feet on stand, R5 put her hand on the hand holders, NA-D secured the straps around wrist/hands and back, R5 appeared very upset, repeating "I'm scared, I'm scared." NA-G and NA-D continued to attempt to calm R5. R5 continued to yell "I don't like the stand" and arms at that time started to slip out of EZ stand with her body slowly lowering. R5 appeared distressed, "calling out I'm going to fall." NA-G was able to pull up her pants and transferred R5 to bariatric wheelchair at which time R5 immediately calmed down. On 7/9/15, at 7:09 a.m. R5 was dressed, sitting in a wheelchair, wanted to go outside to the patio. Staff stated R5 was up at 6:00 a.m. at which time morning cares were completed. - At 9:08 a.m. two aides and one nurse attempted to toilet R5. R5 was screaming and yelling, refusing cares.	F 323	**F323** • **Resident # 5 has had a new comprehensive assessment completed related to her decline in transfers and mobility and significant change MDS has been completed.** • **Any residents at St. Olaf Residence (SOR) who uses a mechanical device for transfer will have the transfer completed in a safe manner.** • **Nursing staff will be educated on proper use of mechanical lifts for resident transfers. Nursing staff should report any change in resident transfer ability to unit nurse so new assessment and proper equipment can be implemented.**	

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F 323	Continued From page 46 R5's diagnoses included paranoid schizophrenia, bipolar disorder, incontinence, lumbago (low back pain) and obesity indicated on the undated Resident Admission Record. The Care Area Assessment (CAA) dated 1/6/15, indicated R5 used a wheelchair, had physical limitations, was at risk for falls due to unsteady gait, transferred independently and for staff to assist as needed. R5's care plan dated 1/9/15, indicated R5 was independent with bed mobility, transferring, w/c [wheelchair] locomotion, walks very short distance (a few steps) with unsteady gait and requires occasional assist with wheelchair locomotion. The quarterly Minimum Data Set (MDS) dated 4/7/15, indicated R5 had moderate cognitive impairment, was independent with bed mobility, transfers, and walking. Review of physician progress notes dated 6/4/15, indicated R5 was very limited in her ambulation, gets around in a wheelchair due to chronic DJD [degenerative joint disorder] of the knees and knee pain. During an interview on 7/8/15, at 8:01 a.m., LPN-A stated the EZ stand was the only way they can get R5 up which she generally refuses but hollers more with the hoyer. LPN-A further stated they tried the Hoyer awhile ago and it did not work. During an interview on 7/8/15, at 8:08 a.m., NA-G stated the Hoyer tipped over one time. R5 was	F 323	• **DON/Designee to check 24 hour board and review for any changes in resident transfers and mobility changes.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audit will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015** • **Resident 24 and 46 experienced no negative effects from the deficient practice.** • **All residents have the potential to be affected by the deficient practice.** • **Resident #24's aluminum grab bar was secured to the bathroom wall by maintenance on July 9, 2015.**	

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	245387	A. BUILDING _____ B. WING _____	07/10/2015

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F 323	Continued From page 47 over the bed at the time, so she was lowered down and that is why they don't use it. NA-G stated she was told the bruises on her arms and legs were from when R5 recently fell. NA-G stated it takes two or more staff to help R5, she will fight them, will not let them roll her to the front so they could wash her back and bottom when she was in the bed, so they use the EZ stand. NA-G verified R5 was slipping out of the EZ stand, stating "we report it, they are aware of it, maybe they need to get a different EZ stand, I don't know." NA-G then showed surveyor the nursing assistant treatment sheet which indicated R5 was assist of two for transfers and assist of one for wheelchair. During an interview on 7/8/15, at 9:42 a.m. LPN-A stated R5 will fight cares, yell during any that she does let staff complete. LPN-A stated a body audit should be completed on bath days, on 7/4/15 R5 refused her bath thus a body audit was not done. LPN-A stated he had observed her in the EZ stand and if the belt was put on correctly and she cooperated by holding on properly, "it works well." During an interview on 7/8/15, at 10:33 a.m. LPN-A stated the Hoyer was never used to transfer R5, just to get her up off the floor when she fell. LPN-A further stated to his knowledge the Hoyer never tipped over when staff was using it, they have always used the EZ stand, "R5 can transfer herself from wheelchair to bed and does do this." During an interview on 7/9/15, at 8:07 a.m. LPN-A stated R5 was now a Hoyer lift due to therapy changing it yesterday. LPN-A stated there are no assessments for use of the Hoyer, but residents	F 323	• **The brown and black matter around the bottom of the grab bar (where it meets the tile) was cleaned and sanitized by housekeeping on July 9, 2015.** • **Wheelchair armrests will be repaired or replaced for resident 24, and 46 by completion date of August 19, 2015.** • **In addition to the maintenance repair logs at each nursing station for notification to maintenance of needed repairs, maintenance will also conduct five weekly environmental room audits that include wheelchair preventative maintenance and safety review. Maintenance will maintain these records for a period of 12 months.**	

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F 323	Continued From page 48 are assessed by therapy for use of the EZ stand. The assessment for the EZ stand was requested. LPN-A stated "it was before my time, I will look for it." - At 8:13 a.m. LPN-A stated he could not find it and was requesting medical records to look for it. - At 8:21 a.m. DON further stated R5 was assessed by physical therapy yesterday and deemed not safe to use the EZ stand so staff now uses the Hoyer. - At 9:31 a.m. the physical therapy director (PTD) stated there is no assessment to use the EZ stand and that nursing or therapy can change to use of the Hoyer if transfers are unsafe, but that therapy needed orders for the EZ stand assessment. PTD stated "I didn't know about the use of the EZ stand, we never recommended it." - At 11:23 a.m. NA-H stated they have used the EZ stand for the past two to three weeks and that R5 was complaining, "we told the nurses." - At 2:40 p.m. PTD stated they have always assessed for EZ stand safety but do follow what the facility policy stated for transfers. During an interview on 7/10/15, at 8:56 a.m. LPN-A stated the nursing assistant care sheet for 7/6/15 and 7/7/15, indicated to use the EZ stand with assist of two staff. Review of the facility policy, Lift - Sit to Stand dated 4/1/2008 directed that staff must be trained in lift use and safety precautions and transfer according to manufacture direction guidelines. The policy lacked direction for assessment of resident prior to use. Grab bar: On 7/6/15, during room observation R24's aluminum grab bar on right side of toilet was not	F 323		

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F 323	Continued From page 49 connected to wall; it was loose, moved back and forth and had brown/black matter around the bottom of grab bar where it met the tile. During an environmental tour on 7/8/15, at 1:00 p.m. the maintenance manager (MM) stated he would come back to re-anchor the grab bar. The regional manager housekeeping (RMH) stated housekeeping would clean and disinfect the bathroom and staff would be re-educated on cleaning. R24 was admitted to the facility on 6/25/14, with diagnoses of hypertension, urinary incontinence, and leg amputation below the knee. Care Area Assessment (CAA) analysis of findings dated 7/3/14, indicated R24's level of assistance varied from independent to assist of one. CAA indicated R24 had new left below the knee amputation (LBKA), staff was to assist as needed. CAA indicated R24 directed staff to assist with toileting. In addition CAA indicated R24 was at risk for falls related to usage of psychotropic medication and new LBKA. Care Plan dated 2/13/15, indicated R24 was independent with all activities of daily living (ADL's) which included ability to transfer, toilet, dress, bathe, and move around corridor with wheelchair and walker with prosthetic and required set up as requested. The Minimum Data Set (MDS) dated 3/30/15, indicated R24 was cognitively intact, required supervision, set up help only for walking in room and corridor. MDS also indicated R24 was not steady but was able to stabilize without staff assistance for moving from seated to standing	F 323	• **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 323	Continued From page 50 position, walking, and turning around and had lower extremity impairment on one side. Wheelchair armrest: R24's wheelchair armrest on the right side was missing a large area of cushion which exposed the top of a screw on the right armrest right where the resident's arm would have been placed. During an environmental tour on 7/8/15, at 1:00 p.m. the maintenance manager (MM) stated he would replace the armrest. Care Plan dated 2/13/15, indicated R24 was independent with all activities of daily living (ADL's) which included ability to transfer, toilet, dress, bathe, and move around corridor with wheelchair and walker with prosthetic and required set up as requested. R46's wheelchair was observed on 7/7/15, at 9:25 a.m. to have right armrest missing. During an environmental tour on 7/8/15, at 1:00 p.m. RMH verified and stated he would get a replacement. R46 was admitted to the facility on 5/28/14, with diagnosis of dementia, hemiplegia or and hemiparesis obtained from the quarterly MDS dated 6/11/15. In addition the MDS indicated R46 required extensive one person assist with bed mobility and activities of daily living and required extensive assist of two with transfers. R46's previous MDS dated 3/12/15, indicated R46 had moderate impaired cognition. On 7/8/15, at 2:25 p.m. housekeeping site	F 323		

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F 323	Continued From page 51 supervisor (HSS) stated they were not aware of any of the environmental problems observed and indicated he wanted to meet with his staff to retrain them. HSS also stated if staff went into a room and saw a problem, they were to record it in the maintenance log located on each floor's nurse station. HSS stated he checked logs twice a day, and every month did spot checking, one floor per week. - At 2:42 p.m. MM stated he relied on logs to get maintenance problems fixed. On 7/9/15, at 7:44 a.m. MM stated he did not keep a record of environment unit spot checks. - At 8:03 a.m. MM indicated they had preventative logs downstairs and repairs were done on a monthly basis. He had no logs or documentation of prior repairs. Accidents/Falls policy revised 2/14, indicated "The facility strives to promote safety, dignity, and overall quality of life for its residents by providing an environment that is free from any hazards for which the facility has control and by providing appropriate supervision and interventions to prevent avoidable accidents." The policy did not indicate who was responsible for ensuring resident care equipment was in good repair to promote safety.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 52 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 ensure monitoring of side effects for Sertraline (an antidepressant) for 1 of 5 residents (R37). In addition, facility failed to monitor adverse side effects for 2 of 5 residents (R41, R3), failed to follow through with pharmacist recommendations for 1 of 5 residents (R41) and failed to implement a physician order for 1 of 5 residents (R46) reviewed for unnecessary medications. Findings include: R37 did not receive side effect monitoring. On 7/8/15, at 7:12 a.m. to 8:20 a.m. and 7/9/15, at 8:08 a.m. to 10:00 a.m. R37's was observed	F 329	**F329** • **Resident #37, #41, and #3 have had a medication review consultant pharmacist, documentation of side effects and adverse reactions monitoring are in place. Completion date: August 11, 2015. Residents #37, #41, and #3 did not experience any negative effects from this deficient practice.** • **Any resident receiving an anti-depressant or anti-psychotic has the potential to be affected by the deficient practice.** • **Other residents that are receiving psychotropic medications are being monitored for side effects.** • **Licensed nurses and TMA's will be educated on unnecessary drug policy.** • **DON/designee will audit to monitor compliance 2x a**	

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F 329	Continued From page 53 lying in bed and never left his room and staff would go into room to assist him or bring him his food. On 7/9/15, at 8:08 a.m. when approached and asked about his medications and his mood R37 stated he was stable, was not flying high and was neither a parasite. R37 indicated he was aware of all the medications he has currently taking. R37's psychotropic drug use Care Area Assessment (CAA) dated 10/1/14, indicated R37 received an antidepressant related to the diagnoses of depression and directed staff to administer medications per orders and monitor for effectiveness and or side effects. R37's psychotropic drug use care plan dated 12/30/14, indicated R37 received an antidepressant related to diagnosis of depression. The care plan directed staff to administer medication per orders and to monitor for effectiveness and/or side effects of medications. R37's diagnoses included bilateral amputee and depression obtained from quarterly Minimum Data Set (MDS) dated 3/26/15. R37's Physician Orders dated 7/6/15, revealed R37 had an order for Sertraline 25 milligrams (mg) three tablets (75 mg) orally every morning for depression. On 7/9/15, at 10:06 a.m. nursing assistant (NA)-B when asked if she regularly worked and assisted R37 and she knew his mood and behaviors NA-B stated she worked with R37 occasionally and if he put the call light on and required assistance. NA-B stated R37 was never depressed or sad	F 329	**week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015** • **Pharmacy Recommendations for resident #41 have been forward to the physician and the physician has addressed the recommendations.** • **Other residents with pharmacist recommendations have had their recommendations forwarded to the physician for follow up.** • **System for communicating pharmacist recommendations – monitoring for follow up has been reviewed and revised.**	

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F 329	Continued From page 54 and in fact he made her laugh at times and did not have any problems with behaviors and stayed in his room most of the time. On 7/9/15, at 10:15 a.m. licensed practical nurse (LPN)-A went through the medical record showed surveyor June 2015 Treatment Administration Record (TAR) sheets which had side effect monitoring. When asked to show July TAR side effects documentation LPN-A stated it would be in the nurses Treatment book. -10:18 a.m. LPN-A went through R37's TAR and the Medication Administration Record (MAR) verified R37 did not have documentation in both records where side effects were being monitored. LPN-A stated he would add it and thought someone may have forgotten to add it to the July TAR. On 7/9/15, at 1:49 p.m. the consultant pharmacist (CP) stated she would have expected the facility to do some kind of documentation of side effects monitoring. When shown a copy of the side effects monitoring the facility used she stated the facility was supposed to follow the facility policy. She further stated she had done the last review in mid-June and was yet to do this month and would have caught the irregularity. On 7/9/15, at 9:48 a.m. the director of nursing (DON) stated the orders were printed by Merwin Pharmacy and then the nurse did a first and second check to ensure everything was there. DON acknowledged the side effect monitoring should have been in place. R41 did not receive adequate monitoring for adverse side effects for the use of olanzapine	F 329	• **Education to licensed nurses and TMA's related to facility expectations for communication related to pharmacy recommendations and follow up with physician.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015.** • **Resident #46 orders for trazodone have been clarified with physician and R46 is receiving medications according to physician order.** • **Orders for other residents are transcribed accurately during end of month changeover of medication sheets.**	

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F 329	Continued From page 55 (Zyprexa-antipsychotic). The Physician Orders dated 7/31/14, revealed R41 had an order for olanzapine 5 mg one tablet orally at bedtime, citalopram (Celexa-antidepressant) 20 mg one tablet orally daily, mirtazapine (Remeron-antidepressant) 15 mg one tablet orally at bedtime, Trazodone (antidepressant) 50 mg one tablet orally at bedtime as needed and lorazepam (Ativan-antianxiety) 0.5 mg one tablet orally one tablet orally three times daily and 0.5 mg one tablet orally every four hours as needed (PRN). R41's psychotropic medication use CAA dated 3/4/15, indicated R41 received psychotropic medication due to diagnosis of depression, anxiety and directed staff to administer per orders and to monitor for side effects and effectiveness. R41's psychotropic drug use care plan dated 3/8/15, indicated R41 received psychotropic medication, directed staff to administer medication per physician order and to monitor for effectiveness of medication and side effects. Review of the the psychotropic side effect monitoring record for May and June 2015 indicated "orthostatic b/p [blood pressure] every month lie/sit/stand." The record lacked evidence of documentation that orthostatic b/p's were completed. R41's diagnoses included depression and anxiety disorder obtained from the quarterly MDS dated 6/3/15. Review of Consultant Pharmacist Communication to Nursing dated 6/16/15, indicated side effect monitoring (orthostatic BP) needed to be	F 329	• **Licensed nurses and TMA's have been educated in regards to transcription of discontinued meds and monthly changeover of medication sheets.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audit will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 329	Continued From page 56 completed according to the physician's order to monitor side effects. On 7/8/15, at 8:25 a.m. R41 was observed lying in bed sleeping with parenteral (intravenous) nutrition hooked up to her hanging next to her bed. On 7/8/15, at 12:30 p.m. R41 was observed lying in bed, dressed with shoes on. R41 stated she had a nice lunch, "it was very good." On 7/9/15, at 8:50 a.m. LPN-D verified orthostatic BP's should be completed as ordered, "they should be done by the nurses." - At 1:54 p.m. the DON stated she expected staff to follow facility policy and/or physician orders for orthostatic blood pressures. - At 2:09 p.m. the CP stated she noted last months orthostatic blood pressure were not done, and had emailed recommendations to nursing reminding them. "I would expect that they complete them." R3 did not receive adequate side effect monitoring for the use Seroquel (Quetiapine Fumarate-used depression). On 7/8/15, at 7:24 a.m. R3 was observed in dining room watching television and no behaviors were noted at that time. R3 was admitted to the facility on 2/21/12, admission diagnoses included schizo-affective, delusional disorder and vascular dementia. The Physician Orders dated 11/8/13, indicated R3 had Seroquel 300 mg, two tablets at bedtime and Depakote (Divalproex-used to treat manic	F 329		

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F 329	Continued From page 57 episodes related to bipolar disorder and manic depression) 500 mg, two tablets at bedtime. The CAA analysis of findings dated 11/12/14, indicated R3 was on antipsychotic medication with treatable medical condition such as heart disease and had impaired balance during transitions. Care plan dated 3/7/15, indicated R3 received antipsychotic medication related to schizoaffective and bipolar disorders. R3 was at risk for falls related to impaired mobility and psychotropic medication use evidenced by total assist with transfers. The TAR for April, May and June 2015 was reviewed. The record also included "orthostatic b/p [blood pressure] every month lie/sit/stand" was to be done for side effect monitoring. However, the treatment record for April, May, and June 2015 lacked of evidence of documentation of the monthly orthostatic BP's being monitored for side effects from the antipsychotic medication. A review of the consultant pharmacist monthly record of medication regimen dated 6/16/15, revealed a request for an orthostatic blood pressure. On 7/9/15, at 8:55 a.m. when asked LPN-A reviewed treatment sheets where orthostatic blood pressures were supposed to be documented and confirmed that they were not being monitored/documented in April, May and June. On 7/9/15, at 2:40 p.m. CP stated there was no regulation to do orthostatic blood pressures	F 329		

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F 329	Continued From page 58 monthly, but it should be general to monitor for side effects after a fall. Orthostatic blood pressures were on treatment sheets and expected to be done. CP noted in June 2015 when she looked back at May 2015 sheet, made recommendation they be done. They were on treatment sheet but monitoring was omitted. On 7/9/15, at 1:54 p.m. DON stated she expected staff to follow facility policy and/or physician orders for orthostatic blood pressures. The unnecessary drugs - antipsychotic drugs policy dated 4/1/08, revision date 4/09, indicated: ..."5. Monitor side effects of medications. a. If resident experiences a decline in functional status, it may be a side effect of the medication. b. review side effects, contact physician if indicated." In addition the policy Unnecessary Drugs-Antipsychotic Drugs revised April 2009, directed staff to monitor the effectiveness or the side effects of the antipsychotics however did not address monitoring for antidepressant side effects. The manufacturer's package insert for Seroquel from Cardinal Health dated 5/2/13, indicated patients would be at risk for orthostatic hypotension (a fall in blood pressure when changing positions). "Quetiapine may induce orthostatic hypotension (form of low blood pressure) associated with dizziness, tachycardia and, in some patients, syncope, especially during the initial dose-titration period, probably reflecting its adrenergic antagonist properties. Orthostatic hypotension, dizziness, and syncope (temporary loss of consciousness caused by a fall in blood pressure) may lead to falls. Quetiapine should be used with particular caution in patients with	F 329		

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F 329	Continued From page 59 known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease (refers to a group of conditions that affect the circulation of blood to the brain, causing limited or no blood flow to affected areas of the brain) or conditions which would predispose patients to hypotension (dehydration, hypovolemia and treatment with anti-hypertensive medications)." Failure to follow through with pharmacist recommendations for R41: R41's Review of the Record of Medication Regimen Review indicated the CP had completed monthly medication reviews from 1/13/15 through 6/16/15, along with any recommendations/findings. A recommendation provided by the CP on 7/9/15, was dated 4/15/15, and indicated "her [R41] medications include Celexa 20 mg daily, Zyprexa 5 mg at bedtime, Remeron 15 mg at bedtime, Trazodone 50 mg at bedtime prn and Ativan 0.5 mg three times daily & 0.25 mg prn. She receives the prn Ativan daily and the Trazodone less frequently. Would a trial reduction of one of these medications be appropriate at this time? Or please document ongoing need for 2 antidepressants (Celexa & Remeron) as well as multiple bedtime meds (Remeron, Trazodone, Zyprexa & Ativan)." Review of the chart records revealed the recommendation had never been forwarded to the physician by nursing. During an interview on 7/9/15, at 10:54 a.m. the Health Dimension Consultant (HDC) verified	F 329		

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F 329	Continued From page 60 there were recommendations made by the pharmacist on 4/15/15, but "we can't find the letter from the pharmacist and am not sure if it was addressed." During an interview on 7/9/15, at 2:09 p.m. the CP stated she had completed her medication review on 4/15/15 and a Consultant Pharmacist Communication to Nursing letter had been sent. CP stated she will give the physician 60 days to answer and/or would address it sooner if the physician had been in and/or if it needed to be addressed immediately. CP stated she had not done so yet as R41 had been in the hospital in May. Facility failed to implement a physician order for R46: The Physician Orders dated 7/31/14, revealed R41 had an order for olanzapine 10 mg one tablet orally every morning, olanzapine 10 mg, two tablets (20 mg) orally at bedtime, Trazodone HCL 50 mg tab, 1/2 tab (25 mg) orally at bedtime and Trazodone HCL 50 mg tab, may repeat 1/2 tab (25 mg) orally times one as needed before 2:00 am. R46's delirium and psychotropic medication use CAA dated 9/12/14, indicated R46 had changes in cognition in the past quarter, had moderate cognitive impairment and used psychotropic medication due to depression, anxiety and psychotic disorder. The CAA directed staff to administer medications per physician orders and monitor for effectiveness and side effects and notify physician of changes. R46's care plan dated 9/16/14, indicated R46 was	F 329		

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F 329	Continued From page 61 on Trazodone (antidepressant), Zyprexa, and Prozac (antidepressant) and to monitor for medication effectiveness and side effects. Review of a Consultant Pharmacist Communication to Physician dated 9/16/14, indicated "her [R46] medications include Zyprexa 10 mg twice daily and Trazodone 25 mg at bedtime, may repeat X 1 [times one]. She has not used the repeat dose. Could a reduction of Trazodone to 25 mg at bedtime prn sleep be tried to evaluate ongoing need? or please document contra-indications to such and attempt." Physician response to recommendation signed 11/18/14, indicated "DC [discontinue] scheduled trazodone @ [at] hs [bedtime] & keep prn as written." The order was noted 1/13/15, by nursing. Review of the Record of Medication Regimen Review indicated the CP had completed monthly medication reviews from 10/14/14 through 6/16/15, along with any recommendations/findings. An irregularity was noted in November and December 2014, but none for 1/13/15 through 6/16/15. Review of the MAR indicated R46 received the scheduled Trazodone 25 mg at bedtime from March through July 8, 2015, although the February MAR indicated the scheduled Trazodone dose was discontinued 1/13/15. R46's diagnoses included dementia, anxiety and depression obtained from the quarterly MDS dated 6/11/15. On 7/8/15, at 8:14 a.m. R46 was observed being pushed in a wheelchair by an aide out of her room, dressed and groomed. R46 stated to	F 329		

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F 329	Continued From page 62 surveyor she was hungry for breakfast. On 7/9/15, at 8:20 a.m. R46 was observed sitting in her wheelchair in her room singing loudly. On 7/9/15, at 12:59 p.m. LPN-F verified the physician order was signed 11/18/14, had not been addressed until 1/13/15, and then "put back on the MAR in March for some reason." LPN-F verified R46 had been receiving the scheduled trazodone medication, and stated "It's a med error, it is what it is." On 7/9/15, at 1:54 p.m. the CP stated she had asked for a Trazodone reduction again in November and December of 2014 and noted it "got done" in January 2015. CP stated "I have her as PRN Trazodone, I thought it was reduced, I usually check the MAR, but missed it." Review of the facility Unnecessary Drugs-Antipsychotic Drugs-revised April 2009, directed staff to monitor the effectiveness or the side effects of the antipsychotics but lacked direction on monitoring by the consultant pharmacist.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were free of medication errors for 1 of 3 residents	F 332		

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F 332	Continued From page 63 (R28). Findings include: R28 was admitted to the facility 2/24/11, with admission diagnosis of quadriplegia, aphasia, spinocerebellar disease (gun shot wound), and adult failure to thrive. R28 was able to communicate with a talking computer. The quarterly Minimum Data Set (MDS) dated 4/15/15, indicated R28 was cognitively intact, minimally depressed, and required extensive assist of two staff for bed mobility, and transfers; and extensive assist of one staff for all other activities of daily living. The annual Care Area Assessment (CAA) dated 1/14/15, indicated R28 was dependent upon staff for hydration, tube feeding and medications. On 7/9/15, at 9:30 a.m. a medication administration via tube feeding was observed. Licensed practical nurse (LPN)-B used good hand hygiene, checked placement of the feeding tube with an air bubble, checked for residual, and then administered three medications. LPN-B prepared omeprazole (an acid reduction medication, Senna syrup (for constipation) and carvadopa/levodopa (a medication to reduce Parkinson like symptoms) and a tube feeding without fluid flush between individual medications and Jevity 1.5 8 oz. When asked LPN-B stated they give a 60 Milliliters (ml) flush prior to meds and a 60 ml flush after meds (total of 120 milliters (ml), as part of the 240 ml of free water through the day. LPN-B verified she had not flushed between individual medications, and had not known that was a standard of practice.	F 332	**F332** • **Resident #28 was assessed and had no ill effects from this deficient practice.** • **There are currently no other residents at the facility that are receiving medications through G-tube.** • **LN shall receive education on tube feeding medication administration policy.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 332	Continued From page 64 On 7/9/15, at 11:23 a.m. the director of nursing (DON) verified she would expect flushes in-between medications, since that was the standard of practice. The Gastrostomy Tube-Administration of Medications dated 4/1/08, and last revised 2/15/13, lacked the current standard of practice for medication administration via tube feeding. The Medication Administration from a Cart policy dated 4/1/08, indicated It is the facility's policy to administer all medications and treatments in a safe and effective manner.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 3 residents (R14) was free of insulin medication errors. Findings include: On 7/6/15, at 5:44 p.m. licensed practical nurse (LPN)-E administered "scheduled Novolog 14 units" with dinner and sliding scale 12 units for a "total of 26 units of Novolog insulin. " LPN-E did not allow dry time for the alcohol skin prep, used the swab and then immediately injected the insulin. LPN-E then took off her gloves, and carried the needle to the sharps container and	F 333		

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F 333	Continued From page 65 tipped it in without gloves. R14 did not complain when the alcohol swab was used. While checking medications it was noted that the scheduled dose of Novolog insulin was 12 units, and the total Novolog administered should have been 24 units. R14 was admitted to the facility 8/5/02, with re-admission 11/25/14, with diagnoses including cerebrovascular accident with left hemiparesis (inability to use the left side of the body), diabetes mellitus, peripheral neuropathy and renal insufficiency. The annual Care Area Assessment (CAA) dated 3/18/15, indicated R14 was cognitively intact and had minimal depression. In addition the CAA indicated R14 required extensive assistance of two staff for bed mobility, transfers, and toilet use, and extensive assistance of one for dressing and was totally dependent on staff for locomotion. R14's quarterly Minimum Data Set (MDS) dated 6/17/15, indicated R14 had no issues with memory loss; had modified independence with decision making skills and had no depression. The MDS indicated R14 was totally dependent of one staff for toilet use, two staff for transfers, and extensive assistance of one staff for all other activities of daily living (ADL). On 7/8/15, at 10:00 a.m. R14's face sheet and insulin administration record were requested, but not provided (only oral medication sheets were provided). On 7/9/15, at 11:23 a.m. the director of nursing (DON) stated, "I would expect [LPN-E] to follow the facility policy."	F 333	**F333** • **Resident #14 is receiving insulin as ordered by physician.** • **All residents receiving insulin could be affected by this deficient practice. Consultant Pharmacist to review medication orders for all residents receiving insulin.** • **Education provided to licensed nurses on insulin administration.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 333	Continued From page 66 The Insulin Administration policy dated 4/1/08, indicated Medications given by injection will be physician ordered and will be administered following professional standards of practice by a licensed professional....Check the physician's order to make sure of the correct type, dosage, and time of administration.	F 333		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. This had the potential to affect 30 of 55 residents who were served food out of the kitchen and used the equipment on the floors. Findings include: On 7/6/15, at 3:24 p.m. the following equipment sanitation problems were observed and verified during the kitchen tour and the unit kitchenettes where food was served out of with the dietary service manager (DSM):	F 371	**F371** • **There were no negative outcomes to residents when the facility failed to ensure that equipment sanitary procedures were followed that would minimize the possibility of food borne illness.** • **All residents have the potential to be affected by this deficient practice.** • **The food service director/designee will ensure that cleaning schedules for kitchen equipment are followed.** • **All food staff will be educated on the correct sanitation procedures.**	

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F 371	Continued From page 67 -The can opener shaft which was attached to the base at end of the kitchen prep table was observed with dark brown to black sticky matter that built-up above the blade. DSM verified the can opener was not clean. When asked if the cook had used it that afternoon DSM shook her head and stated "no" removed it from the holder and took a swipe of the black sticky matter above the blade and stated she was going to put a sign up for staff to clean it after each use. -The microwave in the kitchen was observed to have heavy yellow dried food splashes and spatters in the inside top and sides. During the tour DSM asked the evening cook (C)-A if he had used it but C-A stated he had not used the microwave during his shift yet. DSM stated she would have it cleaned. 3rd Floor Kitchenette On 7/6/15, at 3:27 p.m. the microwave located on the 3rd Floor kitchenette was observed seated on top of a low stand at the end of the kitchenette by the window next to the toaster. Upon opening the microwave it was observed to have yellow red food splashes, spattered all over the inside of the microwave and heavy build-up of food debris. In addition the toaster was observed to have heavy thick coat of bread crumbs built up. -At 3:43 p.m. DSM verified the microwave was covered with heavy dried food debris. DSM stated "Am not giving an excuse for it not being clean but the residents here are on the go." DSM acknowledged the microwave and toaster were supposed to be maintained clean. On 7/7/15, at 12:45 p.m., 7/8/15, at 2:12 p.m. during a random observation the microwave with dried food splashes, spattered inside the microwave still not cleaned.	F 371	• **Dietary Service Manager/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015** • **The housekeeping staff of BSG maintenance of Green Bay Inc. will clean dining and kitchenettes daily, including equipment.** • **These areas will be monitored by BSG supervisor/designee on a daily basis and will be documented on the temperature recording and cleaning log.**	

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F 371	Continued From page 68 1st Floor Kitchenette On 7/6/15, at 3:35 p.m. during the kitchenette tour with DSM the microwave was observed to have heavy food splashes spattered all over the inside and was covered with food debris. DSM verified the microwave was not kept clean. 2nd Floor Kitchenette On 7/6/15, at 3:38 p.m. DSM verified the refrigerator had multiple splashes of red juice on the door and on the bottom. In addition the microwave was covered with heavy yellow dried food splashes spattered all over the inside. -At 3:44 p.m. when asked who cleaned the floor kitchenette areas and appliances DSM stated housekeeping was responsible for cleaning the areas including the microwaves and the refrigerator. On 7/7/15, at 12:30 p.m. and 7/8/15, at 7:17 a.m. during a random observations the microwave remained with dried yellow food splashes and spatters inside. On 7/7/15, at 12:35 p.m. during a subsequent kitchen follow up tour the microwave in the kitchen was still observed to have heavy dried on yellow food splashes, and spatter inside. DSM verified the microwave had not been cleaned as indicated during the initial kitchen tour on 7/6/15. DSM asked the day cook (C)-B if she had used the microwave but she stated she had not used the microwave during her shift. When asked who was responsible for cleaning the microwave DSM stated "everyone is passing a buck am going to have it cleaned and an ultimately am accountable [C-A] did not clean it last night."	F 371	• **ED/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 371	Continued From page 69 On 7/9/15, at 8:42 a.m. the regional manager of housekeeping verified inside the microwave on 1st Floor still had dried food splashes and spatters. When asked who was responsible for cleaning the equipment he showed surveyors a log hanged to the wall by the fridge which indicated the housekeeping staff cleaned the fridge, freezer and eye wash station. He stated "we can add to it for the microwave" he also verified the bottom crispy drawer was broken/cracked and indicated maintenance would be. In addition, he verified the refrigerator still had red spills below the door seal of the fridge door even though it had been marked as cleaned since 7/6/15. -At 8:53 a.m. the regional manager approached surveyor stated he had gone through all the other floors and verified the microwaves were not clean. He indicated he was going to have them all deep cleaned that day and daily moving forward. He further stated he would be adding the microwave cleaning to the empty column as he pointed to the Temperature Reading and Cleaning log. Cleaning Instructions: Can Opener, Microwave Oven, Refrigerators and Toasters policies dated © 2010, directed staff "The can opener will be cleaned after each use. The microwave oven will be kept clean, sanitized and odor free. The refrigerators will be washed thoroughly inside and outside with detergent and followed by a sanitizer at least once every month, or as needed. Spills and leaks will be wiped up as they are noticed. The toaster will be cleaned after each use."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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	245387	A. BUILDING _____ B. WING _____	07/10/2015

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F 425	Continued From page 70 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interiview and document review, the facility failed to ensure proper technique was used for insulin administration for 3 of 3 residents (R51, R14, R69) observed for insulin administration. Findings include: R51's injection was observed on 7/6/15, at 5:30 p.m. licensed practical nurse (LPN)-E injected Novolog (medication used to control blood sugar) 5 units (U) insulin into resident R51 without cleaning the skin. When asked how she insured she was not injecting staph or orther skin germs into the subcutaneous tissue LPN-E stated, "He	F 425	**F425** • **Resident #51, #14, and #69 were assessed and have not been affected by this deficit practice.** • **All residents receiving insulin could be affected by this policy and competency for all licensed nurses r/t insulin administration has been completed.** • **Education provided to licensed nurses on insulin administration.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 425	Continued From page 71	F 425		

has skin sensitive, and don't [sic] like alcohol. Several residents don't like the alcohol swab. I can prove it with R14." LPN-E verified she had not let the alcohol dry to see if that reduced the sting of the penetration of the needle on sensative skin. LPN-E then took off her gloves, and carried the needle to the sharps container.

R14's insulin injection was observed on 7/6/15, at 5:44 p.m. LPN-E administered "scheduled Novolog 14 U" with dinner, and sliding scale 12 U for a "total of 26 U of Novolog insulin." LPN-E did not allow dry time for the alcohol skin prep, used the swab and then immediately injected the insulin. LPN-E then took off her gloves, and carried the needle to the sharps container and tipped it in without gloves. R14 did not complain when the alcohol swab was used.

R69's insulin injection was observed on 7/6/15, at 5:51 p.m. LPN-E gave R69 2 U of Novolog insulin. LPN-E did use an alcohol swab for R69, but then injected the insulin immediately. LPN-E did not allow dry time for the alcohol skin prep. LPN-E then took off her gloves, and carried the needle to the sharps container and tipped it in without gloves. R69 did not complain when the alcohol swab was used.

On 7/6/15, at 6:05 p.m. LPN-E did verify that for an alcohol prep to be effective, it must have time to dry "evaporate" from the skin.

On 7/9/15, at 11:23 a.m. the director of nursing was interviewed and stated, "I would expect [LPN-E] to follow the facility policy."

The Insulin Administration policy dated 4/1/08, indicated .....17. Cleanse the area with the alcohol

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F 425	Continued From page 72 wipe and administer the insulin at a 90 degree angle. .. The Infection Control (General) policy dated 4/1/08, indicated...An infection control program is designed and implemented in order to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities for implementation of physician orders for 2 of 5 residents (R46, R3) reviewed for unnecessary medications. Findings include: On 7/8/15, at 8:14 a.m. being pushed in a wheelchair by an aide out of her room, dressed and groomed. R46 stated to surveyor she was	F 428		

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F 428	Continued From page 73 hungry for breakfast. On 7/9/15, at 8:20 a.m. R46 was observed sitting in her wheelchair in her room singing loudly. R46's diagnoses included dementia, anxiety and depression obtained from the quarterly Minimum Data Set (MDS) dated 6/11/15. R46's delirium and psychotropic medication use CAA dated 9/12/14 indicated R46 had changes in cognition in the past quarter, had moderate cognitive impairment and used psychotropic medication due to depression, anxiety and psychotic disorder. The Care Area Assessment (CAA) directed staff to administer medications per physician orders and monitor for effectiveness and side effects and notify physician of changes. R46's care plan dated 9/16/14, indicated R46 was on Trazodone (antidepressant), olanzapine (antipsychotic) and Prozac (antidepressant) and to monitor for medication effectiveness and side effects. The Physician Orders dated 7/31/15, revealed R41 had an order for olanzapine 10 mg one tablet orally every morning, olanzapine 10 mg, two tablets (20 mg) orally at bedtime, trazodone HCL 50 mg tab, 1/2 tab (25 mg) orally at bedtime and trazodone HCL 50 mg tab, may repeat 1/2 tab (25 mg) orally times one as needed before 2 am. Review of a Consultant Pharmacist Communication to Physician dated 9/16/14 indicated "her (R46) medications include Zyprexa 10 mg twice daily and Trazodone 25 mg at bedtime, may repeat X 1. She has not used the repeat dose. Could a reduction of Trazodone to 25 mg at bedtime prn sleep be tried to evaluate	F 428	**F428** • **Resident #46, and #3 have had their medications reviewed by consultant pharmacist and appropriate recommendations have been made.** • **All residents who are prescribed psychotropic medications are at risk for this deficient practice. Consultant Pharmacist is to review with DON all residents on psychotropic medication to assure that dose reductions have been recommended within the past 12 months.** • **DON provided education to the pharmacist consultant to assure that a systematic approach is being utilized to identify irregularities of physician orders for unnecessary meds.**	

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F 428	Continued From page 74 ongoing need? or please document contra-indications to such and attempt." Physician response to recommendation signed 11/18/14 indicated "DC [discontinue] scheduled trazodone @ [at] hs [bedtime] & keep prn [as needed] as written." The order was noted 1/13/15 by nursing. Review of the Medication Administration Records (MAR) indicated R46 received the scheduled trazodone 25 mg at bedtime from March - July 8, 2015, although the February MAR indicated the scheduled trazodone dose was discontinued 1/13/15. Review of the Record of Medication Regimen Review indicated the consultant pharmacist (CP) had completed monthly medication reviews from 10/14/14 - 6/16/15 along with any recommendations/findings. An irregularity was noted in November and December 2014, but none for 1/13/15 - 6/16/15. During an interview on 7/9/15, at 12:59 p.m. licensed practical nurse (LPN-F) verified the physician order was signed 11/18/14, was not addressed until 1/13/15 and then "put back on the MAR in March for some reason." LPN-F verified R46 had been receiving the scheduled trazodone medication, stating "It's a med error, it is what it is." During an interview on 07/09/2015, at 1:54 p.m. CP stated she asked for a trazodone reduction again in November and December and noted it "got done" in January. CP stated "I have her as prn trazodone, I thought it was reduced, I usually check the MAR, but missed it."	F 428	• **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 428	Continued From page 75	F 428		

R3 did not receive adequate side effect monitoring for the use Seroquel (Quetiapine Fumarate-used depression).

On 7/8/15, at 7:24 a.m. R3 was observed in dining room watching television and no behaviors were noted at that time.

R3 was admitted to the facility on 2/21/12, admission diagnoses included schizo-affective, delusional disorder and vascular dementia.

The Physician Orders dated 11/8/13, indicated R3 had Seroquel 300 mg, two tablets at bedtime and Depakote (Divalproex-used to treat manic episodes related to bipolar disorder and manic depression) 500 mg, two tablets at bedtime.

The CAA analysis of findings dated 11/12/14, indicated R3 was on antipsychotic medication with treatable medical condition such as heart disease and had impaired balance during transitions.

Care plan dated 3/7/15, indicated R3 received antipsychotic medication related to schizoaffective and bipolar disorders. R3 was at risk for falls related to impaired mobility and psychotropic medication use evidenced by total assist with transfers.

The TAR for April, May and June 2015 was reviewed. The record also included "orthostatic b/p [blood pressure] every month lie/sit/stand" was to be done for side effect monitoring. However, the treatment record for April, May, and June 2015 lacked of evidence of documentation of the monthly orthostatic BP's being monitored

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F 428	Continued From page 76 for side effects from the antipsychotic medication. A review of the consultant pharmacist monthly record of medication regimen dated 6/16/15, revealed a request for an orthostatic blood pressure. On 7/9/15, at 8:55 a.m. when asked LPN-A reviewed treatment sheets where orthostatic blood pressures were supposed to be documented and confirmed that they were not being monitored/documented in April, May and June. On 7/9/15, at 2:40 p.m. CP stated there was no regulation to do orthostatic blood pressures monthly, but it should be general to monitor for side effects after a fall. Orthostatic blood pressures were on treatment sheets and expected to be done. CP noted in June 2015 when she looked back at May 2015 sheet, made recommendation they be done. They were on treatment sheet but monitoring was omitted. On 7/9/15, at 1:54 p.m. DON stated she expected staff to follow facility policy and/or physician orders for orthostatic blood pressures. The unnecessary drugs - antipsychotic drugs policy dated 4/1/08, revision date 4/09, indicated: ..."5. Monitor side effects of medications. a. If resident experiences a decline in functional status, it may be a side effect of the medication. b. review side effects, contact physician if indicated." In addition the policy Unnecessary Drugs-Antipsychotic Drugs revised April 2009, directed staff to monitor the effectiveness or the side effects of the antipsychotics however did not address monitoring for antidepressant side	F 428		

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F 428	Continued From page 77 effects. The manufacturer's package insert for Seroquel from Cardinal Health dated 5/2/13, indicated patients would be at risk for orthostatic hypotension (a fall in blood pressure when changing positions). "Quetiapine may induce orthostatic hypotension (form of low blood pressure) associated with dizziness, tachycardia and, in some patients, syncope, especially during the initial dose-titration period, probably reflecting its adrenergic antagonist properties. Orthostatic hypotension, dizziness, and syncope (temporary loss of consciousness caused by a fall in blood pressure) may lead to falls. Quetiapine should be used with particular caution in patients with known cardiovascular disease (history of myocardial infarction or ischemic heart disease, heart failure or conduction abnormalities), cerebrovascular disease (refers to a group of conditions that affect the circulation of blood to the brain, causing limited or no blood flow to affected areas of the brain) or conditions which would predispose patients to hypotension (dehydration, hypovolemia and treatment with anti-hypertensive medications)." Review of the facility Unnecessary Drugs-Antipsychotic Drugs policy revised April 2009, directed staff to monitor the effectiveness or the side effects of the antipsychotics but lacked direction on monitoring by the consultant pharmacist.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 78 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 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 lock a medication cart on 1st Floor nurse cart which held residents biologicals, treatments and medications (insulin's,	F 431	**F431** • **No residents were affected by this deficient practice.** • **All residents have the potential to be affected by this practice.** • **LN was immediately educated on standard of practice to ensure medication cart is locked at all times, when they are not administering medication.** • **Education provided to licensed nurses and TMA's on standard of practice to ensure medication cart is locked at all times when they are not administering medication.** • **ED/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 431	Continued From page 79 anti-depressants, anti-psychotropic, blood pressure medication, laxatives among other prescribed medication) reviewed during a random observation and the facility failed to ensure that medications were not expired for all newly admitted resident and for 2 of 2 residents (R37, R26) on the unit that received insulin. Findings include: Medication carts: On 7/9/15, at 7:26 a.m. to 7:32 a.m. during a continuous observation the nurse cart was observed unlocked and unattended. The key lock to the medication cart was observed to be fully extended in the unlocked position and the cart was located across of the nursing station. During the observation several unauthorized staff including nursing assistants (NA)-A to stand in front of the cart and walked back into the nursing station; NA-C went back and forth and residents R11, R31 and R7 went past the cart and could have opened the unlocked the cart as the knob was fully extended outward. -At 7:32 a.m. licensed practical nurse (LPN)-A walked into the nursing station and sat directly across from the cart and at the same time LPN-B returned to the cart and stood in front of the cart. -At 7:34 a.m. LPN-B was observed lock the cart. When approached immediately and asked about the unlocked and unattended cart LPN-B acknowledged she had left the cart open when asked if she was supposed to lock it she stated "Yes I usually bring my cart with me ..." On 7/9/15, at 9:43 the director of nursing (DON) stated the nurses were supposed to follow facility policy when asked what the policy was DON stated "I gave you a copy of it."	F 431		

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F 431	Continued From page 80 Merwin LTC Pharmacy policy and procedure manual dated 10/22/2013, directed "1. Medication rooms, carts and supplies are locked, and only licensed nurse, the Consultant Pharmacist and those lawfully authorized are allowed access to medications. Each nurse authorized to use medicine room or cart keys must carry these keys at all times while on duty. These keys are not to be left in a drawer or loaned out for any reason..." Expired medications: The first floor medication refrigerator contained Apisol (Mantoux solution-tuberculin skin test (TST) opened and dated 3/1/15. A second Apisol container was not open, but was dated 5/26/15. The last admission to the unit arrived on 7/3/15, and received the expired Apisol. In addition, the first floor medication cart contained a Novolog (medication used to control blood sugar) flex pen with no cap to prevent contamination of the pen for R37. Also a second Novolog flex pen with no date in which it was opened for R26. On 7/6/15, at 6:00 p.m. LPN-E verified the expired Apisol, which had been given to R79. The Medication Storage in the Facility policy dated 10/22/13, indicated....10. Outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, or unlabeled or without secure closures are immediately removed from stock, disposed of according to facility procedures for medication destruction and re-ordered from the pharmacy if a current order exists...	F 431		

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F 431	Continued From page 81 The package insert information Last revised on 15 July 2009, by JHP Pharmaceuticals LLC read, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The package insert information last revised on 17 April 2015, By Novo Nordisk read, "Once a cartridge or NovoLog FlexPen or NovoLog FlexTouch is punctured, it should be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. A NovoLog FlexPen or NovoLog FlexTouch or cartridge in use must NOT be stored in the refrigerator. Keep the NovoLog FlexPen or NovoLog FlexTouch and all PenFill cartridges away from direct heat and sunlight. Unpunctured NovoLog FlexPen or NovoLog FlexTouch and PenFill cartridges can be used until the expiration date printed on the label if they are stored in a refrigerator. Keep unused NovoLog FlexPen or NovoLog FlexTouch and PenFill cartridges in the carton so they will stay clean and protected from light."	F 431		
F 441 SS=D	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;	F 441		

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	245387	A. BUILDING _____ B. WING _____	07/10/2015

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F 441	Continued From page 82 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were used during cares for 3 of 4 residents (R25, R75, R20) reviewed for activities of daily living (ADLs). Findings include: R25 was continuously observed on 7/8/15, at 7:31 a.m. to 8:06 a.m. nursing assistant (NA)-B was observed enter R25's room went to the	F 441	**F441** • **Resident #25, #75, and #20 suffered no ill effects from this deficient practice.** • **All residents requiring assistance with ADL's have the potential to be affected by this deficient practice.** • **Nursing staff has been educated on infection control policy including hand washing, and donning and doffing of gloves.** • **DON/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015**	

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F 441	Continued From page 83 bathroom and set up water in a wash basin. Prior to assisting R25 NA-B cued R25 she was going to wash her face after she lay a towel on her chest area; cleaned ears asked R25 if she had pain. Then cued R25 as she removed the sweater and R25 was able to help facial hairs remained visible from standing at the foot of the bed. NA-B then proceeded to clean under R25's armpits and under the breast and then dried R25 with a towel. Then covered R25 stated she was leaving the room to get lotion removed gloves left the room went to the supply room never washed her hands. Came back briefly donned another pair of gloves applied lotion to R25 arms, hands, neck area and face. -At 7:42 a.m. NA-B cued R25 she was going to uncover her lower body then covered the upper body, provided R25 front and back pericares applied cream on her bottom applied incontinent pad under R25's bottom; applied a small amount of powder never changed her gloves. Still wearing the same gloves move the footboard of the bed to get to the other side of bed. Fastened the incontinent pad came over to the other side took two wash towels out of the basin which she had used to do pericare squeezed excess water removed R25's socks then wiped down her lower extremities which included R25's both thighs, legs and feet then dried R25 off applied lotion to the areas and then socks. Still wearing the same gloves NA-B touched linen, R25's clothing and opened the dresser drawers; pulled and adjusted R25's pants and applied R25's house slippers. -At 7:55 a.m. NA-B picked the room and linen and moved R25's wheelchair close to the bed removed gloves never washed her hands; went to the bathroom got another pair applied it then picked the linen in the room some more dumped the water in the basin in the toilet and then	F 441		

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F 441	Continued From page 84	F 441		

removed gloves never washed her hands came over R25's bedside assisted her to get her sweater; used the remote to raise the bed adjusted R25's clothing applied the transfer belt cued R25 she was going to assist her to get up.
-At 8:05 a.m. NA-B proceeded to comb R25's hair then left the room came back with two plastic cups with some water set up the tooth brush and brushed R25's teeth as she cued her to open her mouth never still washed hands to this point.
-At 8:08 a.m. NA-B took R25 to the dining room then came back to R25's room.

On 7/8/15, at 8:10 a.m. NA-B acknowledged not changing gloves after the pericares and stated was supposed to wash her hands each time when gloves were removed "I always do change my gloves I have gloves in my pockets and wash my hands."

On 7/9/15, at 9:43 the director of nursing stated (DON) the staff was to follow facility policy for hand washing and gloving.

R75 was observed on 7/8/15, at 8:06 a.m. as NA-D provided morning cares. She was putting shoes and socks on R75. NA-D transferred resident in wheelchair to bathroom to use the toilet. NA-D washed hands, applied gloves, provided peri-care, removed urine soaked pad and disposed in a plastic bag. NA-D assisted resident off toilet and provided cues for resident to wash hands and brush teeth. NA-D assisted resident into wheelchair, removed gloves, brought resident into dining room, applied food protector, had not washed hands yet. When asked NA-D verified had not washed hands and went into resident room to wash hands. NA-D stated policy

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F 441	Continued From page 85 was to wash hands after toileting resident. On 7/8/15 at 8:21 a.m. licensed practical nurse (LPN)-A stated staff should remove gloves and wash hands with resident's care. They can use hand sanitizer two times and then must wash hands. During resident care they wash hands for each resident. They should wash hands right after they complete resident cares before bringing them out of their room. On 7/9/15, at 1:50 p.m. when asked about hand washing DON stated she expected nursing assistants were to follow facility policy on hand washing. R20 was observed on 7/8/15, at 7:31 a.m. A dressing change was observed for R20 with LPN-C. LPN-C put on gloves to remove old gauze bandage, then started a dirty linen bag with the same gloves. Removed the gloves to look for supplies then left the room (did not wash hands after removing gloves). LPN-C returned with a package of gauze and a roll of Kerlix. LPN-C cleaned hands with waterless hand sanitizer, the donned gloves, cleaned the wound with saline, applied the gel and cut dressings to size before applying Kerlix to cover the wound. LPN-C then removed his gloves, put supplies away and left the room. - At 7:55 a.m. LPN-C was asked about the missed handwashing opportunities, LPN-C indicated he cleansed his hands with hand sanitizer before putting on gloves. LPN-C verified he did not wash his hands after removing gloves, prior to entering the medication/supply room to gather supplies for the wound change. R20's morning cares were observed on 7/8/15, at	F 441		

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F 441	Continued From page 86	F 441		

9:57 a.m. NA-A was observed to provide cares to R20. NA-A donned a pair of gloves and prepared basin with soap and water per direction of R20, while R20 washed her face. NA-A had to step out to get a fitted sheet. NA-A removed her gloves, them exited the room without washing her hands.
- At 10:02 a.m. NA-A returned to the room with a bag of laundry; then re-applied gloves without performing any hand hygiene.
- At 10:17 a.m. positioned in bed to ensure the back of the body was cleansed. R20 was rolled left, with great exertion. NA-A noticed the bed was wet in the peri area. NA-A scrubbed the mattress and then continued with the bath. R20 had purple discoloration (in varying shades) from upper thighs (above gluteal fold) which included the buttocks. NA-A cleaned stool from the peri folds twice with the same washcloth and then used that wash cloth to pat an area of denuded skin on the left upper buttocks approximately 3.5 to 4.0 centimeters (cm)x 2.5 cm with crusted area of yellow debris. NA-A applied an ointment to the denuded area with the soiled gloves. NA-A then removed the soiled gloves and did not wash hands. When asked about hand hygiene, NA-A verified she had not completed hand hygiene per the facility policy.

R20 was admitted to the facility 5/1/13, with diagnoses of congestive heart failure, malunion fracture of the right ankle, abscess and cellulitis of the right leg and diabetes mellitus type II, had a history of pressure ulcers, and stroke with hemiparesis (inability to move half the body) per the Admission Record.

The annual Care Area Assessment (CAA) dated 8/20/14, indicated R20 had a cognitive loss, had a recent decline in ADL and required assistance in

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F 441	Continued From page 87 all ADL. R20 refused care one to three days in the in the last seven days and had a history noncompliance with treatments. R20 was at risk for pressure ulcers related to limited mobility, incontinence, and nutritional status. Staff should assist with repositioning, incontinence cares, monitor for decline, and notify MD with changes The Care Plan dated 8/26/14, indicated R20, had a history of pressure ulcers, had a pressure reduction mattress, and should be monitored for signs and symptoms of skin break down related to incontinence and immobility. R20 was to be assisted with repositioning, and staff should notify the doctor and the wound team to follow as needed. The care plan lacked new directions to check and change or reposition every 2 hours, related to residents wish to stay in bed for six weeks due to a self-diagnosed "pulled muscle" in her neck. The quarterly Minimum Data Set (MDS) dated 5/18/15, indicated R20 was cognitively intact, had no depression and did not reject cares. R20 required extensive assist of two staff for bed mobility, a total mechanical lift for transfers, toilet use. R20 was always incontinent and did not have a pressure ulcer. Hand Washing policy dated 2008, directed "The facility requires staff to wash their hands after each direct resident contact for which hand-washing is indicated by accepted professional practice. Hand-washing is also conducted as per recommendations from the CDC guidelines." The policy lacked to address what staff was supposed to do each time gloves were removed prior to re-applying or donning a clean pair.	F 441		

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F 441	Continued From page 88 Center for Disease Control (CDC) Protocol for Hand Hygiene and Glove Use Observations Glove use directed "1. In general, gloves should be worn prior to contact with patients at the treatment station and potentially contaminated surfaces (e.g., dialysis machine, environmental surfaces). Note: all items/surfaces at the dialysis station are considered potentially contaminated. Gloves should always be changed between patients and between clean and contaminated sites on the same patient. Holding a glove in one's hand instead of wearing it is not considered acceptable. Glove use does not preclude the need for hand hygiene after removing gloves. Examples of situations when gloves should be changed: 1. After contact with blood or body fluids 2. After completing tasks at one patient station before moving to another station 3. After contacting a potentially contaminated site before moving to a clean site ..."	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, facility failed to ensure a clean and safe environment was maintained for 9 of 55 residents (R20, R25, R80, R41, R24, R31, R5, R64, R40).	F 465		

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F 465	Continued From page 89 Findings include: During an environmental tour on 7/8/15, at 1:00 p.m. with the housekeeping site supervisor (HSS), maintenance manager (MM), regional manager housekeeping, (RMH) and human resources manager (HRM), the following environmental concerns were noted and verified: On 7/6/15, during dining observation two chairs in the first floor dining room were observed to have cracks on the seats vinyl peeling off which exposed the foam underneath and three dining room table pedestals were noted dirty.In addition in the third floor dining room six chairs with also noted cracks. RMH stated they would replace chairs in the first floor dining room. He further stated they would replace cushions or chairs in the third floor dining room, as cracks were an infection control concern. HSS stated table pedestals were cleaned Monday and Thursdays each week. On 7/7/15, R20's grab bar on right side of bed was observed with heavy buildup of brown to black debris on the bar. During the tour RMH stated housekeeping would clean grab bar. On 7/6/15, R25's toilet riser was observed to have brown matter around the sides. During the tour RMH stated it would be cleaned and disinfected. On 7/6/15, R80's bathroom tile was observed with buildup of brown matter around the bottom of aluminum grab bar and dirty grout around base of toilet. On the wall below soap dispenser, there was white material sticking on the bathroom tile. The faucet had constant dripping after verifying faucet was turned off. During the tour RMH stated	F 465	**F465** • **There were no negative outcomes to residents when the facility failed to ensure a clean and safe environment.** • **All residents have potential to be affected by this deficient practice.** • **The two chairs from first floor dining room and six chairs from third floor dining room identified as needing repairs have been repaired or replaced. Completion date: August 19, 2015.** • **The three table pedestals in third floor dining room identified as dirty have been cleaned.** • **Dining room table pedestals are scheduled to be cleaned on Mondays and Thursdays every week.**	

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F 465	Continued From page 90 maintenance would get adhesive remover and housekeeping would clean the tile. MM stated he would have to re-adjust the faucet handle so it would not hit the back of sink. On 7/6/15, R41's bathroom floor was observed to be sticky with buildup in corners of grout/tiles, around toilet and under toilet seat. Plaster was missing on left corner, approximately two feet up from floor on wall going into the main bedroom. During the tour RMH stated he would get grout cleaner and use doodle bug to get around edges. MM stated he would patch missing plaster. On 7/6/15, R24's bathroom tile behind and to side of the sink was observed to have white material stuck to tile. Grout around base of aluminum grab bar had heavy black/brown buildup, entrance to bathroom had buildup of brownish matter where carpet met tile, and carpet was starting to fray. Paint was missing off lower bottom of bathroom door frame and wooden door. During the tour RMH stated housekeeping would clean residue, mop thoroughly and get transition strip where carpet met tile. MM stated he would paint door frame. On 7/7/15, R31's room was observed with scrapes and gouges on wall towards bathroom. There was a malodorous odor in the room; piles of magazines were noted; all drawers were open and clothing was hanging out. The wheelchair was had a buildup of debris. During the tour MM stated he would paint wall. RMH stated nursing assistants would clean the room. RMH further stated wheelchairs were tagged and brought downstairs as needed to clean when they got dirty.	F 465	• **Housekeeping manager/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date: August, 19, 2015.** • **Resident #20's grab bar on the right side of the bed was cleaned and sanitized on July 7, 2015** • **Resident 25's toilet riser was cleaned and sanitized on July 7, 2015.** • **Resident #80's bathroom tile around the bottom of the aluminum grab bar was cleaned and the dirty grout around the base of the toilet was cleaned on July 7, 2015.** • **Resident 41's bathroom floor was stripped, washed and waxed on July 7, 2015. The plaster repair will be completed by August 19, 2015.**	

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F 465	Continued From page 91 On 7/7/25, R5's floor tile was observed to be very sticky, but was not wet. During the tour RMH stated housekeeping would scrub floor top. HSS stated floor was cleaned twice daily. On 7/7/25, R64's bathroom door was observed with gouges approximately one and a half feet from the bottom. During the tour MM stated they were in the process of putting door plates on. On 7/6/15, R40's room was observed with multiple food containers dated 12/17, and another container undated. In the room were two walkers and a wheelchair stored; bags, containers, and wash basin were observed partially underneath bed; bathroom floor transition strip was missing and floor was cracked and had black marks. During the tour RMH stated nursing assistants would take care of personal belongings and nurses would take care of the equipment. RMH verified there was no transition metal plate to hold tile and had spare tiles and would replace them. On 7/815, at 2:25 p.m. HSS stated they were not aware of any of the environmental problems observed and indicated he wanted to meet with his staff to retrain them. HSS also stated if staff went into rooms and saw a problem, they were to record it in the maintenance log located on each floor's nurse station. HSS stated he checked logs twice a day, and every month did spot checking, one floor per week. - At 2:42 p.m. MM stated he relied on logs to get maintenance problems fixed. On 7/8/15, at 2:38 p.m. HSS stated he had a schedule for wheelchair cleaning. If housekeeping cleaned a room, they would clean the wheelchair then and stated they took it	F 465	• **Resident #24's bathroom tile behind and to the side of the sink was thoroughly cleaned of the white material noted. The room was mopped thoroughly and transition strip applied July 7, 2015. Maintenance painted door frame and wooden door. Completion date: August 19, 2015.** • **Resident #31's room has had scrapes and gouges on wall repaired. Completion date: August 19, 2007** • **The nursing assistants cleaned the resident's room including picking up clothes and magazines on July 7, 2015. The wheelchair has been cleaned of debris as of July 7, 2015.** • **Resident #5's floor tile was thoroughly cleaned on July 7, 2015.**	

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F 465	Continued From page 92 downstairs, sprayed, disinfected and put it in storage. They cleaned it while resident was sleeping. On 7/9/15, at 7:44 a.m. MM stated he did not keep a record of environment unit spot checks. - At 8:03 a.m. MM indicated they had preventative logs downstairs and repairs were done on a monthly basis. He had no logs or documentation of prior repairs. Cleaning Instructions: Floors, Tables and Chairs policies dated © 2010, Facility daily cleans (every room every day including weekends) policy included: "clean with disinfect toilets, handrails (by toilets), sinks, call lights, door handles, light switches, table tops, counter tops, vinyl chairs. Wet mop all hard surfaced floors. Spot clean walls, doors and switch plates. Report any maintenance problems to supervisor." Cleaning Instructions: Floors, Tables and Chairs policies dated © 2010, Tasks performed when thorough cleaning policy included: "clean door and door frames. Wall washer all areas ceiling to floor: including vertical walls to remove cob webs (move any items away from wall). Clean chairs rungs, legs, arms, also bed frames, inside and out of trash can. Bathroom: wash sink with cream cleanser, pipes under sink, mirror, counter tops, above light, top of medicine cabinet, all towel racks, all dispensers including toilet paper dispensers, toilet, handrails, call lights, light switches, baseboards, dust mop wet mop floor." Cleaning Instructions: Floors, Tables and Chairs policies dated © 2010, directed staff "Kitchen and dining room floors, tables and chairs will be kept clean and sanitary. Procedure: 3. Dining room	F 465	• **Resident #64's bathroom door plate will be replaced by August 19, 2015.** • **Resident 40's multiple food containers dated December 17, 2014 and other outdated containers were removed from the room. Unneeded equipment in the room and bathroom were removed from the resident's room on July 7, 2015. Missing transition strip was replaced and floor marks were removed on July 7, 2015.** • **Housekeeping and nursing staff will be educated to report unsafe or unsanitary condition including messy rooms, outdated food containers in resident rooms, missing floor strips, soiled floors and missing floor tiles.** • **Completion date: August 19, 2015.**	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

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F 465	Continued From page 93 tables will be cleaned and sanitized after each meal. 4. Dining room chairs will be wiped off (as appropriate) after each meal using a clean cloth and clean, hot soapy water. Cloth covered chairs may be brushed off or vacuumed. 5. Dining room chairs (wooden or metal legs, arms, etc.) should be cleaned once a week with sanitizing solution."	F 465	**F465** • **Maintenance Director/designee will audit five rooms weekly x4 weeks, then monthly x2 to monitor compliance.** • **Maintenance Director/designee will keep a record of environmental room audits to include resident room safety and repair needs.** • **Maintenance Director/designee will maintain completed room audit forms for twelve calendar months.** • **ED/designee will audit to monitor compliance 2x a week for one month, then once weekly for two months, or as directed by QAA.** • **Findings of audits will be reviewed at QAA Q month x 3.** • **Completion date by: August 19, 2015.**	
F 492 SS=C	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure 1 of 1 resident (R6's) which had a toilet in the room met the applicable codes/ regulations. Findings include: On 7/8/15, at 3:15 p.m. during entrance conference the facility was aware of the bedroom which had a toilet in the room. On 7/8/15, at 4.00 p.m. the administrator provided a copy of the room 107 waiver dated January 20, 2015, for review. Review of the waiver revealed the following information "This waiver will remain in effect until October 31, 2015 or until the resident currently assigned to room 107 was assigned to a different bedroom or departs the	F 492		

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
	245387	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411

(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 492	Continued From page 94 facility, whichever occurs first. Please be advised that all waivers are subject to review as deemed necessary by the Department. Please remember that all alternative measures of conditions attached to a variance or waiver shall have the force and effect of a licensure." On 7/8/15, at 6:30 p.m. surveyor observed the toilet in R6's sleeping area to the right when entering room with sink next to it, and bed located on the opposite left side of the room. During the interview when asked if the facility had enough staff available to make sure he got the care and assistance he needed without having to wait for a long time R6 stated he used his toilet as he was pointed to it. R6 stated he transferred to the toilet using a sliding board and was able to use the collapsible grab bars attached to the wall to ease his transfers on and off. Review of R6's current physician's orders dated 6/1/15, indicated diagnoses including traumatic amputation of leg and morbid obesity. The quarterly Minimum Data Set (MDS) dated 5/6/15, indicated R6 needed limited assistance of one staff with toileting. On 7/9/15, at 12:56 a.m. the administrator was aware of the toilet in the R6's room 107, the administrator stated "we have a waiver for that." She further stated he had asked R6 if he wanted a privacy curtain and he stated no as it was in his way. The administrator stated she was aware that privacy was a right, and she could get him a curtain.	F 492	**F492** • **The administrator provided the waiver for room #107 dated January 20, 2015 for review and will apply for a waiver renewal. Completion date: August 19, 2015**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245387	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST OLAF RESIDENCE	**2912 FREMONT AVENUE NORTH MINNEAPOLIS, MN 55411**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on July 08, 2015. At the time of this survey, St Olaf Residence was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 482.41 (b), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, "The Life Safety Code" (LSC), Chapter 19 Existing Health Care. St Olaf Residence is a 4-story building with a basement. The original building was constructed in 1964, is separated from a church with a 2 hour fire rated barrier and was determined to be of Type I (332) construction. The facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection throughout the corridor system, in common areas and areas open to the corridor system and is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 482.41 (b), 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.